

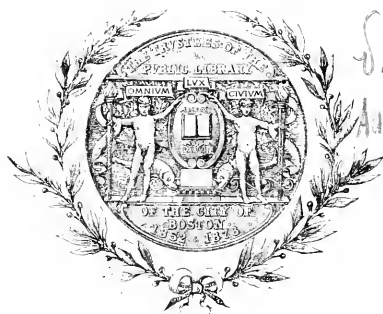
Vol. 18

Aug.

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No. 2551.527



S. 18
Aug-Dec

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VOLUME 18

THE **CHILD**

AUGUST-SEPTEMBER 1953

to DECEMBER 1953

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Social Security Administration
Children's Bureau

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CEREBRAL - PALSIED CHILDREN ATTEND

**HELEN M. WALLACE, M.D.
LEONA BAUMGARTNER, M.D.
WILLIAM COOPER, M.D.**

UNTIL RECENT YEARS most children with cerebral palsy have been considered by the public uneducable and more or less incapable of becoming independent adults able to care for themselves. Few communities have provided special facilities and personnel for their care and education. These children have thus often been neglected and left to fend for themselves as best they could, with the result that for the most part they have been uneducated, untrained, and more or less even unable to care for their daily needs. Ultimately many of them become a permanent burden to society.

Experience, however, has shown, over the past two decades particularly, that habilitation of many of these children is possible.

More recently, organized groups of parents of children with cerebral palsy have done much to promote community activities for these children. They have raised funds to provide special care for their children, have helped to promote research, have allocated funds for the training of personnel, and have worked toward enactment of legislation appropriating

public funds so that more adequate services may be provided for such children.

Many kinds of health and education services are being developed to meet the differing needs of cerebral-palsied children.

The health services include: Diagnostic and treatment services on an out-patient basis; in-patient hospital care; in-patient convalescent and rehabilitation care; care at residential schools; and institutional care for children who are severely retarded in mentality.

Cerebral-palsied receive instruction

As for the schooling of the cerebral-palsied children, some of those in New York City attend public-school classes for various kinds of orthopedically handicapped children—some of them cerebral-palsied. Still others are in public-school classes for various kinds of mentally retarded children, including the cerebral-palsied. A number of cerebral-palsied children are taught at home by public-school teachers, and teachers are also sent by the public schools to give instruction to such children in hospitals, convalescent institutions, and residential schools. Lastly, a number of children are enrolled in the public-school classes that are the subject of this ar-

ticle, namely, special classes in public schools, for cerebral-palsied children.

Each of these services may require a battery of trained personnel, in the fields of pediatrics, orthopedic surgery, physical medicine, physical therapy, psychiatry, psychology, neurology, occupational therapy, speech therapy, nursing, social work, and education, making an adequate program very costly. Small wonder that most governmental authorities have been slow to appropriate funds for many of the services necessary.

Within the past 7 years in New York City four special units for children with cerebral palsy have been developed in the public schools. The first such unit began in 1946, the second in 1950, and two were opened in 1952. Each of the four major boroughs of the city now has such a unit.

At first financial support came from voluntary agencies (the New York Service for Orthopedically Handicapped, the Association for the Aid of Crippled Children, and United Cerebral Palsy of New York). Later the city's Department of Health and Department of Education were able to obtain funds to provide the services.

The first unit was organized as a nursery school and was housed in one of the Health Department's district health centers. Medical guidance



SPECIAL CLASSES IN PUBLIC SCHOOLS

came from an orthopedic surgeon, who also conducted a diagnostic clinic for the cerebral-palsied, in a hospital. Pediatric and nursing assistance came from the well-child conference operated by the health department in the health-center building. Salaries of nursery-school teachers and therapists were provided by one of the private agencies, which also promoted and organized the service for the cerebral-palsied.

Later the unit was moved to a public elementary school, and the other three units, financed partly by private agencies, were opened in similar schools—two classes to a unit.

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Each unit is planned for 25 children between the ages of 4 and 10 years. Personnel for each unit consists of a part-time medical director (who may be a pediatrician, an orthopedic surgeon, a physiatrist, or a neurologist), two full-time physical therapists, one full-time occupational therapist, one full-time speech therapist, one full-time attendant, two full-time teachers, one part-time psychologist, one part-time medical social worker, one part-time public-health nurse, one part-time pediatrician, and one part-time secretary. In addition, the department provides consultation in the fields of ophthalmology and otology when this is needed.

These special cerebral-palsy classes aim to provide education and health services and special therapy, for potentially educable children who are too severely handicapped physically to attend regular or orthopedic classes. The classes work to habilitate as soon as possible children who can be expected to go to regular school later. As soon as a child is able to get along in a special class for orthopedically handicapped children, he is transferred to such a class. Each of the special classes for cerebral-palsied children is established in a school that also has an orthopedic class, in order to facilitate the transfer of a cerebral-

palsied child to the orthopedic class whenever he is prepared for this.

Children are referred to the special cerebral-palsy classes by private physicians and hospital clinics, from whom a complete medical report is obtained. A screening examination is conducted at the school by all the professional personnel of the cerebral-palsy class, and a group decision is made regarding the child's trial admission, or rejection. Each child admitted attends the class for a 3-month trial period, after which the staff makes the decision. When it seems time to discharge a child, this decision also is made on a group basis by the staff. (A copy of the Manual for the Operation of Cerebral Palsy Units in New York City is available upon request to the Bureau for Handicapped Children, New York City Department of Health, 125 Worth Street, New York 13, N. Y.)

Seven requirements listed

A child is admitted to a cerebral-palsy unit (1) if he is between 4 and 10 years of age; (2) if the diagnosis of cerebral palsy is confirmed by the medical staff of the unit; (3) if his admission is recommended by a practicing physician or a treatment agency; (4) if he lives in the borough served by the cerebral-palsy class; (5) if his handicap is too great to permit him to attend a regular or an

orthopedic class, but not so severe as to preclude the possible development of a useful degree of independence; (6) if his mentality is estimated to be normal; (7) if he seems to be ready for group participation, socially and emotionally.

A child is discharged from a unit (1) if his physical condition improves enough to qualify him for an orthopedic or a regular class; (2) if his mentality is found to be too low to permit him to benefit from the cerebral-palsy class; (3) if he does not improve physically at a rate that justifies keeping him in the class; (4) if his behavior is too disruptive to the class; (5) if his family moves out of the borough served by the school; (6) when he reaches the age of 10 years (the upper limit for eligibility at present).

Parents learn about child's needs

One of the important benefits of these classes comes from their relationship with the parents of the children. Parents are encouraged to participate in the day-to-day operation of the class through rotating assignments to the class on a daily basis. They may assist their own and other children with feeding, dressing, toilet care, and so forth. They also help in transporting the children to school and home again. Such participation enables parents to develop a better understanding of the children's needs so that they may carry on better at home after the school closes in the afternoon. One unit holds periodic group meetings with the parents; the discussions are conducted by staff members or other workers in the field.

What do these special school classes accomplish for cerebral-palsied children? As a partial answer to this question, here is a brief statement concerning the class that has been longest in operation. (The figures cover the period from March 1946 to June 1953.)

Of a total of 372 children for whom application was made for admission to the special class, 83 children (22 percent) were found to be eligible and 244 (65 percent) ineligible. Eight percent were referred to a similar

class in another borough, and 4 percent were awaiting screening when these figures were compiled.

Of the 83 children eligible, 65 were admitted. The other 18 were placed on a waiting list to be admitted as vacancies occurred.

The physical handicaps of the 65 children on admission were severe. Ninety percent were unable to dress themselves alone; 79 percent could not walk; 79 percent could not care for themselves at the toilet; 48 percent could not feed themselves; and 43 percent could not even sit up by themselves. It is evident that the selection of these 65 children for the special unit was appropriate, for the classes are planned to serve the very seriously disabled.

As for the 244 children not admitted to the cerebral-palsy class, the reasons were as follows: Other arrangements were made by the parents for 52; 46 of the children were not eligible on account of their residence; 40 failed to complete the tests necessary to determine eligibility; 31 children were outside the age limits; 33 were able to get along in school without the help of the special services; 31 were considered too severely handicapped for the cerebral-palsy class. For 7 children the diagnosis of cerebral palsy was not confirmed, and 4 children died before the admission procedures were completed. It is significant that by means of the screening examination 13 percent of the 244 children were able to carry on their education in regular or orthopedic classes.

During the period of stay in the class covered by this report one-third to almost one-half of the children developed the ability to do certain things essential to their carrying on as independent individuals, in marked contrast to what they could do when admitted.

Of the 65 children admitted to the unit, 38 were discharged after staying for an average of 14.9 school months, and 27 were still in attendance at the time of the report, with an average length of stay, so far, of 12.1 school months.

Fourteen of the 38 children discharged had improved sufficiently to

progress to an orthopedic class in the school within an average period of 14 school months. Eight were found to be mentally retarded; 6 were transferred to another cerebral-palsy school unit in another borough when it opened. Two children became ill and were unable to continue; 2 had such serious behavior difficulties that they could not be kept; 3 were removed by their parents; and the families of 3 moved out of the school district.

Physical improvement too

Apparently the children's group experience often promotes their physical habilitation. Doctors who have known the children for years remark on how rapidly a child's physical function seems to improve as he relaxes in the normal, friendly atmosphere of the class and the school. Parents, too, seem to be able to treat their own children in a more relaxed and normal way after they have been with other cerebral-palsied children. There seems to be real value for parents in helping the staff with other children as well as in seeing how a staff member handles their own child. Thus, one mother who at first rebelled at helping another child with toilet needs came to accept her own child's needs more easily, and she later said that she had gained much through helping the other child. The children's progress at home is, of course, discussed by staff members and parents.

The influence of these classes on the rest of the school has been noticeable. The cerebral-palsied children are encouraged to join in school activities such as general assemblies, and they are seen on the playgrounds. The other teachers observe the clinical approach of the staff team that works with these handicapped children. Principals have pointed out that this has helped the teachers see the children in their own classes more as individuals, and has tended to enable them to deal with problems in a more objective manner. One principal has emphasized that the presence of these very severely handicapped children in his school has helped "character building" in the other pupils; mean-

ing that they had become more tolerant of those in need and kinder to them.

Cost must be counted

One of the important problems to be faced in connection with such classes as these is the cost. In the school year 1952-53 the total cost for a cerebral-palsy unit accommodating 25 children was \$45,319.50 or \$1,813 per child. Of this amount the health services cost \$22,982 or about \$919 per child, and the educational service \$10,400 or \$416 per child.

The transportation to and from the school cost \$11,937.50, or \$477.50 per child.

In addition, approximately \$4,000 worth of equipment and supplies is needed in order to start such a unit. This includes such items as physical, occupational, and speech-therapy equipment; relaxation chairs; standing tables; parallel bars; and typewriters for the children.

The expenditure of \$922 per child for the health services is considerably less than that required to maintain a child for a year in a hospital (\$4,745) or in a convalescent home (\$2,920).

The \$416 per child for educational service might be compared with the cost per child of educating children in orthopedic classes (\$800) and in regular classes (\$400).

Transportation accounts for more than a fourth of the cost of the entire service for the special class.

The costs for health and education services in a unit accommodating 25 children were distributed as follows:

For health services, including special therapy: Medical supervision, \$4,800; physical therapy, \$6,520; speech therapy, \$3,260; occupational therapy, \$3,260; psychologist's services, \$1,250; medical social service, \$1,192; secretarial service, \$1,200; medical coordinator's services, \$1,500 (total, \$22,982). In addition, public-health-nursing service is provided by the Bureau of Public Health Nursing of the Department of Health, through the public-health nurse regularly assigned to the individual public

school, as part of the general school health service.

For educational services: Teaching, \$8,000; attendant service, \$2,400 (total, \$10,400).

These special classes for cerebral-palsied children represent one type of service that seems to be needed by such children.

The classes have been operated so far on an empirical basis, particularly in regard to the types and numbers of personnel necessary to staff the units. Many questions in this regard remain unanswered at the present time.

For example, we do not know if it is essential to provide both physical therapy and occupational therapy. Nor do we know if a medical social worker is necessary or how much of a psychologist's time is needed. Obviously the answers to these questions are important to the children and their parents, and to administrators responsible for planning community services for children with cerebral palsy. This kind of question will be answered, we hope, both through experience in the operation of these units and through a special research study of the functions and the time of the personnel in the classes.

Experimentation needed

We need also to find methods of evaluating more accurately the physical and educational growth and development of the children in special cerebral-palsy school classes. (The data presented here on the children in one class include only very gross indices of physical development and none on educational progress.)

Again, it is possible that the 4-year age level at which children are now admitted might be lowered. Experimentation in this direction is important, for it seems desirable to start the child in the special unit as early as possible.

The current program also does not meet the needs of the child over 10. At present when a child reaches the age of 10, unless he is prepared to attend a regular or an orthopedic class, he is given home instruction. It is possible that much of the progress made by the younger child in the special

class is being lost after his tenth birthday, when he is taught at home; certainly he loses the opportunity of mixing with other children. Therefore plans are now being made to provide special classes for cerebral-palsied children 11-17 years of age. These services for older children will be closely integrated with a program of vocational testing, guidance, training, and placement.

It is possible also that, by providing more adequate medical supervision and physical-therapy services for children in orthopedic classes, we can help many of the children in the cerebral-palsy classes to graduate to the orthopedic classes more quickly. Such services are now being planned.

What is a child worth?

The expenditure of over \$1,800 per child annually for the habilitation of the children in these special classes may be questioned. But from a long-range point of view, the fact that the classes have helped children to change from complete and permanent dependence upon society to some degree of independence and productivity is of great importance, both for the individual and for society. Furthermore, from a purely fiscal point of view, an annual expenditure of \$1,800 per child in these special school units must be compared with the annual expenditure from New York City and State tax funds of \$4,745 (at \$13 per day) for the care of such children in hospitals and residential schools, and \$2,920 (at \$8 per day) in convalescent homes.

When a cerebral-palsied child goes to a special class in a day school the family has the advantage of being able to keep him at home, while all the necessary health and educational services are provided for him. This is important, particularly from the viewpoint of the child's emotional growth and development. It is of the greatest value if one believes, as the present writers do, that insofar as possible a handicapped child should be brought up like other children, rather than with the additional handicap of living away from home. And, after all, it is the child's life that matters most.

WHEN CHILDREN ARE CONVALESCING FROM RHEUMATIC FEVER

Parents discuss common problems with clinic staff

JEANNE KININGHAM

IGERSSHEIMER

CHARLES H. CROTHERS, M.D.

ROBERT B. KUGEL, M.D.

AT OUR pediatric cardiac clinic various staff members have for a long time recognized that the parents of children who are recovering from rheumatic fever have many problems. During the acute stage of the disease the parents' concern is centered on the treatment of the illness. But after that stage has passed, and also the stage when the child is resting in bed, the parents encounter increasing difficulties. For when the doctor says that the time has come when the child may—and should—become more active, the parents are likely to worry much more than they did earlier about what may happen to their child.

Our staff members have always instructed the various parents individually, giving them as much help as possible in their efforts to care for their sick child and restore him to health. But as we all know, people gain confidence through talking together about their common problems. Acting on this idea, the physician who directs the clinic, and the medical social worker assigned to it, introduced a plan for encouraging and helping the mothers by gathering some of them together at the clinic for discussion. (At that time we had not thought of including the fathers.) This was in November of 1951.

The entire staff of the clinic—five doctors, the nurse, and the medical social worker—became a committee to plan for the parents' meetings.

At our first meeting, our planning group defined its purpose. It was to help parents understand rheumatic

fever so that they could do a better job for their convalescent children, and do it with less anxiety. We did not think of the meetings as group therapy, in the sense of uncovering and solving basic emotional problems; but we hoped that the group experience would help to reduce the parents' worries about the child's recovery.

Since our clinic was going to try the group approach as an experiment, we felt that we should limit our goals, and not let the meetings be looked upon as a cure-all for the parents' emotional problems. Nevertheless we felt that through free discussion the parents could help one another to face their common problems with less anxiety. We hoped also that we could help them with the problems by encouraging them to ask questions and by providing information.

Before the meetings could begin, which we hoped would be in 2 months, the staff had many points to settle: How many parents should be invited to join the group? How would they be selected? Who would interview them and explain the project? Who would lead the meetings? How could the discussions be recorded?

We tentatively selected the place for the parents' meetings, at the clinic, and scheduled our own planning sessions for November and December—weekly or biweekly.

Two sessions were devoted to studying criteria for selecting parents. We decided not to limit the group to mothers, for we felt that the children would benefit if the fathers participated also. This turned out to be the right decision, for we learned that although the fathers were in-

clined to think that caring for the sick child was the mothers' job, they at the same time resented being left out.

We decided that 8 to 10 parents would be a good number; a meeting of this size, we believed, would permit full discussion and free exchange of ideas.

When do the parents most need help?

At first we intended not to specify any one stage of rheumatic fever when deciding on the children whose parents were to be asked to participate. But as our discussion went on, we realized that the meetings would be most valuable to the parents of children who were at the stage when they were being restored to activity, partial or full. We felt that during the acute stage of the disease, when the child is very ill, and at the bed-rest stage, when he is quiet, the parents are more able to cope with their problems than when the child is permitted by the doctor to be up and about.

We tried to select parents who were fairly intelligent and thus able

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to contribute to discussions, and who were not too emotionally disturbed themselves. The doctors wondered whether there was any danger that the meetings might release deeper emotional reactions than could be handled comfortably in a group; this, they felt, might defeat our plans. We were pretty sure that this could not be entirely avoided, and so we decided that if it occurred we would offer to

help for considering his group of patients and selecting families that he thought would benefit from parent meetings. After deciding on a family, the doctor discussed its suitability either with the staff, at a regular pre-clinic conference, or individually with the medical social worker, who already knew many of the families. After a family was agreed upon as suitable, the doctor talked to the

their getting acquainted and deciding on specific points for discussion. The parents were also polled with regard to their preference concerning the times when the meetings would be held.

We look for common problems

The medical social worker shared what she had learned from the parents with the rest of our planning group, and we then sifted the information to discover common problems. The group learned that in a number of cases the parents somewhat distrusted the medical management; that they had difficulty in permitting their child to increase his activity, even though the doctor had ordered this; that they were uncertain and fearful as to their child's future health; and that they were worried lest the child would have problems in adjusting in school.

As a month passed and only a few parents had been decided on as group members, we began to realize that we had been too optimistic. December brought slackening of clinic attendance, as well as bad weather and staff absences, and we found it necessary to postpone starting the parents' meetings till March.

The question of leadership for the meetings was solved when the medical social worker, who had had previous experience in group work, was able to arrange to take special time from the social-service department for the project. She provided regular leadership, and two of the doctors took part in all but the first meeting.

The problem of recording the meetings was never satisfactorily solved. It was suggested that we use a tape recorder; also that the leader of the group or a parent might take notes. The latter idea was brought up at the first meeting, and one of the mothers volunteered to write minutes for the one session. After other meetings the leaders attempted to reconstruct the discussions, but were unable to do it except in a cursory way.

At last, one evening in March, at 8 o'clock, three fathers and five mothers gathered in the staff room near the clinic. They sat in comfort-



When their child is in the acute stage of rheumatic fever, the main concern of the parents is, of course, to obtain the best medical care possible, whether at home or in the hospital.

help the individual parents after the meeting was over.

The next step was taken by the doctors, each of whom took responsi-

Pediatrics Out-Patient Clinic. At the time Dr. Kugel was with Grace-New Haven Community Hospital he was also a Commonwealth Fellow in the Child Study Center at Yale University School of Medicine, and an Instructor in the Department of Pediatrics.

Mrs. Igersheimer (then Miss Kiningham), Dr. Crothers, and Dr. Kugel were the discussion leaders at the parent meetings described here.

The authors are indebted to Ruth Whittemore, M.D., Director of the Pediatric Cardiac Clinic of Grace-New Haven Community Hospital, for her interest and help in carrying out this project. Dr. Whittemore is also Director of the New Haven Rheumatic Fever and Cardiac Program, under the Division of Crippled Children, Connecticut State Department of Health.

mother to find out whether she was interested in the project. (Not all the families who were approached showed interest.) After a mother's interest was clear, the medical social worker arranged an interview, preferably with both parents, for final screening and for further explanation of the project.

During the medical social worker's interview with the parents, she studied them with regard to the selection factors we had agreed on, and she obtained an idea of some of their problems concerning their sick child. The worker explained the plans for the meetings and asked the parents what they hoped to gain from the experience. She told them that the first meeting would be devoted to

able chairs arranged in an informal circle. The parents already understood that at this meeting they would help to plan the agenda for future meetings and to make the arrangements.

No doctors were present at this first meeting; this had been agreed upon ahead of time. The medical social worker opened the meeting by suggesting that the parents introduce themselves. She then asked them to tell something about their child's experience with rheumatic fever. These statements brought up specific problems, which seemed to concern all the parents.

One typical question concerned penicillin. All the parents were interested in knowing more about this drug. They wondered why the body did not build up an immunity to it; they asked whether it affected children adversely, and if so, how. One mother said that her child had been given prophylactic doses of penicillin recently, and that she thought that this meant the child wasn't getting along as well as she had hoped, even though the doctor had told her this was not true. The other parents quickly reassured her, telling her that it was merely to prevent the child from getting more infection. The group finally decided that they would ask the doctors some of these questions at the next meeting.

The parents also mentioned problems of their children's school attendance and their behavior, and wondered if they couldn't bring these up at another meeting. Several parents said they didn't know how much excitement a child with rheumatic fever could stand, and they asked at what stage of the disease one should feel free to discipline him. They were also concerned about whether their child might be "spoiled" during the course of the illness. Opinions differed on "spoiling"; some parents felt that it was impossible not to focus special attention on the child at some time during his illness.

When the leader explained that the group would decide how frequently agreed on one-hour evening meetings, they would want to meet, and as to the time of day, the parents unanimously

Tentatively they decided on a total of four weekly meetings, deferring decision on whether to continue beyond that. On this basis, future discussion was outlined as follows: Second meeting, specific questions for the doctors in relation to medical information; third meeting, problems of management of the child's behavior; fourth meeting, summary questions.

Questions for the doctors

The plan to have the medical social worker find out the concerns of the individual parents ahead of time, and then to let the parents discover at the first meeting that their problems were common ones, turned out to be sound. At this meeting the absence of the doctors permitted the parents to bring out their questions about medical management without fear of jeopardizing their relationship with the clinic's medical personnel. As the staff had planned, the leader succeeded during the first meeting in directing the discussion in such a way that the possibility of having the doctors come to the next meeting was brought up by several parents.

The parents were particularly disturbed because they thought they had been told different things by different doctors. They had expressed this feeling first individually to the medical social worker in the early interviews, and later they discussed it in the meetings. At the last meeting of the series they felt secure enough to express their resentment directly to the doctors. The doctors encouraged them

to bring out into the open their feelings of bewilderment and confusion, and answered many questions. This helped the parents discover that doctors had logical reasons for handling situations differently.

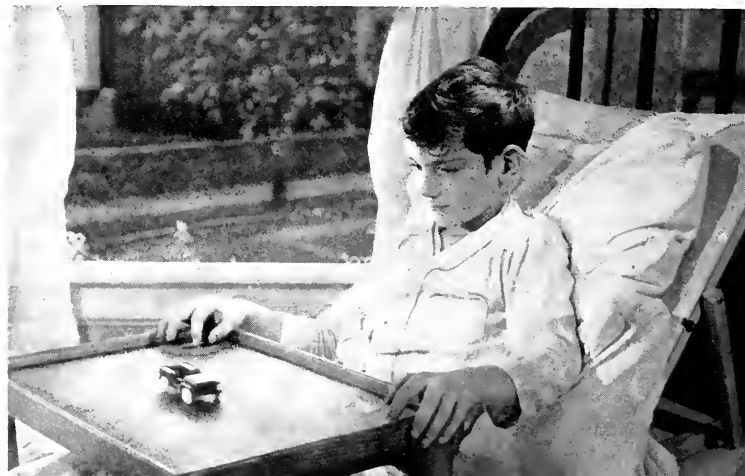
Penicillin continued to be a central theme throughout all the meetings. At first the leaders were concerned about why the parents had not asked about this earlier. Why did they need assurance now? It appeared that penicillin was symbolic of their hope for the child's recovery and future health. It would "solve everything"—it was a cure-all—there would be no more colds and therefore no recurrences of rheumatic fever!

The parents finally were able to ask the stark question: "Do you mean there is nothing I can do that I am not doing now to prevent another attack of rheumatic fever?"

This in turn led the leaders to wonder what was the effect of telling the parents that penicillin would not cure, nor prevent, rheumatic fever. Were their defenses being broken down without anything else being offered them? Did they need something tangible to do, like giving a pill? These were questions which the staff could not answer, but which certainly should be recognized in planning such group discussions.

At the last meeting, there still seemed to be some confusion in the parents' minds, but later contacts with the staff indicated that the group members had become more able to accept the limitations of treatment.

After the acute stage of rheumatic fever is past, the child must rest in bed. And it is not an easy task for parents to keep him happy, when only quiet occupations are permitted to him.



Many of the specific questions raised by the group related to the future:

One mother asked whether her little girl could have a child after she grew up, despite the fact that she had had rheumatic fever.

The entire group was concerned about whether physical exercise could cause a recurrence of rheumatic-fever attacks. Even at the last meeting it was clear that obeying the doctor's directions for increased activity by the child was a major problem to the parents. One mother admitted that every time the doctor permitted her child more activity she would reduce it by 50 percent.

Parents blame themselves

The parents asked how they could explain rheumatic fever to other people. This question seemed related to their own thinking that perhaps their child was "not so good." Also, did people think they were not giving good care to their child? One mother indicated that she was going to do so well in caring for her child that she would never be at fault again. It was difficult for the staff to convince the parents that they might not have been at fault the first time.

It seemed to the leaders that the parents were better able to accept the limitations of medical treatment when they realized that the fear of another attack was shared by all and that no parent would be to blame should another attack occur. Also, painful in-

formation seemed more bearable when diluted by the group discussion.

The leaders recognized that they could not remove all the parents' fears. The real situation was basically unchanged; their children continued to return to the clinic and continued to take penicillin. While this was happening the parents could not entirely accept the fact that the disease process was no longer present.

At the final meeting the parents were asked if these meetings would have been more helpful to them if they had been held during the acute period of their child's illness. The answer was: "It might have been different if you had told us this earlier." The leaders, however, wondered if this were not like talking about the last war. It was easier to talk about what they had already gone through than to deal with their present situation, such as the need to permit their children increased activity. It was clear that helping the child adjust to getting well was more difficult than helping him to accept illness.

Throughout the period of the meetings, the staff continued to meet regularly to review reports of the discussions. An evaluation of the project was made by the group leaders after the last meeting, and the medical social worker was appointed to summarize the project.

The leaders asked themselves two questions: (1) What did the parents gain from the experience? (2) What did we as staff members learn from it?

Later the doctor suggests that the child become more active. But even with the doctor's approval, many parents find it hard to permit their child such activities as riding a bicycle.



The parents had been encouraged to feel free to return to the clinic and talk with any of the leaders. It was anticipated that they might have further questions about problems the group had discussed. The two doctors who acted as leaders noted that in clinic contacts the parents seemed to carry over a changed attitude toward them. They were able to ask questions of the doctors, which they apparently could not have done previously. One value of the group then was seen in the improved doctor-patient relationship.

Changes in parents noted

Although the group experience seemed to reduce parent anxiety, it did not eliminate it. A month after the conclusion of the group meetings, one mother called her doctor, expressing concern because her daughter had come home from school that day after failing a test and had begun to cry. This led to nervous, jerky movements and the mother thought it might be the beginning of chorea. The staff had some reason to believe that prior to the group meetings this mother might not have been willing to call the doctor in a similar situation. Also, she now showed increased awareness of possible cause-and-effect relationships in regard to the chorea-like movements of her child.

It seemed to the leaders that the group meetings had made the hospital less formidable to the parents. They seemed more relaxed about the disease. One father bluntly stated: "I feel better about rheumatic fever." In the group the parents were able to discuss problems related to the illness, which they had not been able to do before. They seemed to feel safer in a group and to recognize that their concerns were not unique, and thus could raise questions that they would not bring up in the clinic, even when they were repeatedly seeing the same doctor. The assurance of, and through, the group was based on a kinship; they had gone through the same experience.

The leaders felt it would be impossible to measure the value the project had been to themselves as a learning experience. It gave the staff a new

(Continued on page 13)

FOSTER PARENTS SPEAK UP

ESTHER S. MELTZER and MIRIAM WANNE

Part 2

EDITOR'S NOTE: This is the second part of an article that began in our June-July issue. (We shall be glad to send a copy of that issue to any reader who missed part 1.)

In part 1, Miss Meltzer and Miss Wanne told how the Jewish Children's Bureau of

Cleveland began, a few years ago, to hold meetings for foster parents, with the agency welcoming the foster parents' participation in planning. Part 1, which described the first 3 months of the program, ended with the close of the first series of meetings, at the beginning of the summer-vacation period.

How the foster parents had summed these meetings up for themselves we did not as yet know. Our analysis of the first part of our venture, however, could be made with some certainty as to where we had come and what our direction should be.

First, approximately 25 to 30 foster parents had attended each meeting, the majority coming to all three. This, out of a total number of 42 paid foster homes, we considered good. Therefore, we could assume that these foster parents had questions and were seeking answers.

Secondly, the large number of questions raised indicated that we had succeeded in creating an atmosphere in which everyone felt free to ask questions, to raise problems, and to express criticism.

Thirdly, the emphasis, in committee meetings and in group meetings, on the fact that our purpose was to examine together the whys and wherefores of placement became the basis of a new understanding. On this basis the group began to realize that criticism of each other and of ourselves could be helpful, and was necessary if our work was to continue to improve, and that there were no specific answers to the specific questions asked.

Fourthly, the concept of "the agency" began to change. Both the staff and the foster parents began to recognize that *we together* are the agency.

This last point was important not only in relation to the foster parents. These first three meetings had served

to stimulate rethinking by the professional staff about the questions: (1) Why do people become foster parents? and (2) what is the relationship of foster parents to the agency? Our work with foster parents during these 3 months began imperceptibly to change. The foster parents were slowly emerging from the status of quasi-client into the position of fellow worker in a common task, a concept long a part of agency thinking, but now reflected in practice to a degree not known before.

A main topic chosen

The fall of 1948 saw the beginning of the second period of our meetings with foster parents. Analyzing results of the first three general meetings, the planning committee voiced appreciation for the opportunity the meetings had offered for the foster parents to get to know one another and to share experiences. It was helpful to know that their questions and their problems were not unique—not faced by each of them alone. There was a note of vague dissatisfaction, however, in their comments about the fact that the discussions wandered so. They thought it would be more helpful if the meetings were centered around one major subject of discussion.

As this possibility was explored, it became clear that one source of general and major concern was the adolescent foster child. Therefore "Adolescents in placement" was agreed upon as the over-all subject for the current series of meetings.

The group felt that it would be important that we give consideration to how we can help the adolescent foster child grow into independent, responsible adulthood.

What is the agency's role in achieving this aim? What is the foster parents' role? What is the child's?

How can we help the youngster with the task of earning, saving, and spending money?

What is the place of the home and of the school in disciplining the child?

How do we give sound sex information to the adolescent?

And, finally, as a separate topic: What are the special needs, if any, of the displaced European foster child?

In this committee meeting we thought there was complete agreement on the program we were to follow for the year, and in the first general meeting we inaugurated our discussion. The second meeting of the planning committee, however, saw a vehement outburst of pent-up feelings. The attack was led by Mrs. Hart. She, for one, got nothing out of the meetings and thought them a waste of time. Mr. Robins complained that he had come to meeting after meeting expecting answers to his questions, but all he got in reply was more questions. His wife vehemently declared that she wanted us all to know that she, for one, felt she was a complete failure as a foster mother because she had not been able to bring about changes in her foster child.

The storm raged, while every member of the committee added his gust of anger and frustration. The staff representatives, during two lulls, remarked that it was up to this committee to determine what kind of meetings they wanted. If these were not satisfactory, we could plan others according to their suggestions. We were not meeting in order to have the foster parents prove they are good foster parents; this they have done, and do, in their everyday work with the children. What we want and seek from the meetings, we said, is an exchange of experiences so that we can learn from one another. Perhaps there are no specific answers, and perhaps there cannot be any.

The storm died down. Mrs. Hart reflectively commented: "The won-

derful thing about these committee meetings and the large meetings is that you get things off your chest and then feel so much better. It's just like a psychiatrist's office."

Perhaps Mrs. Hart was not so very wrong in her analogy. In our staff analysis of this committee meeting we recognized that what we had expected and hoped would come, indeed had come, and perhaps earlier than we had anticipated. The outburst in the committee meeting had really cleared the air.

Our method had been to raise questions and to encourage free discussion in reply. As a result, the foster parents had brought to the surface many feelings of frustration, including some of the very frustrations that had led them to become foster parents in the first place. The consequent anxiety had to be dispelled before the group could advance unhampered by personal conflict and emotions. The therapeutic value of the outburst was proved by the rapid coordinated strides that were made in all the meetings that followed.

In the second general meeting of this period, the discussion leader spoke of the reactions of the planning committee and encouraged the group as a whole to give critical consideration to our meetings. One after another, the foster parents stated that they had not been satisfied with the meetings to date. They wanted specific answers, and, more than that, an answer to the question: "Why can't we have specific answers?" The caseworkers at this point spoke in a more personal vein of the feelings of frustration we so often experience in our own work with children and their parents.

We stated that we did not ourselves have all the answers. We knew some things about child care that we had learned from the long line of workers preceding us. We had some answers gleaned from other fields of work, like medicine, history, sociology, psychiatry. And we had still other answers from our own personal work experiences. But whether these answers were *the* answers, we could not and would not say. Our purpose in these meetings was to seek answers

together and to admit, if necessary, that we did not have the answers to every question and that it might not be necessary to have a specific answer to each question.

These two fall meetings constituted the crisis and the turning point of our program. Having expressed a sense of frustration, having given vent to an outraged feeling of failure, the group began to evidence a change of attitude. Their interest was sharpened; there was less insistence on "specific" answers; attendance remained at a high level. The increased freedom with which foster parents shared their experiences and reactions, the ease with which they began to challenge one another and staff was exciting. We felt that for both foster parents and staff the purpose and vitality of these discussions were clear.

We change our meeting place

It was interesting that the same dynamics that had been so potent in the planning committee were operative in the large group, and with the same over-all results. There was, in the meetings that followed, a more businesslike air. There were fewer side discussions, and more consideration was given to each member of the group as he presented his point of view. It was with alacrity that the group accepted the suggestion that future meetings be held in the agency's downtown office instead of in the homes of various staff members. And the wonder in their comment, "You mean this is where your staff has its meetings?" marked another step in the direction of higher status as recognized members of the agency's staff. There were repeated references to the general meetings as "our meetings" and to the planning committee as "the board."

The personalities were etched as sharply as before, but all participated in each meeting with more objectivity and with a desire to get the maximum from every discussion.

From January through May 1949, the following topics were discussed in the general meetings:

- 1 What is the meaning that going to work has for the adolescent

foster child, whether it be full-time or part-time work?

- 2 How can we help the adolescent learn to manage his earnings responsibly? In this discussion the group voiced sharp criticism of the agency's policies on allowances and savings plans; and the next meeting saw the establishment of a joint committee of five foster parents and two agency staff workers to study the financial planning for the children and to make recommendations for changes and improvements.
- 3 How is an adolescent foster child prepared for placement and how does the caseworker help him understand his own responsibilities as a member of a foster family? This discussion was based on material presented by a panel of two caseworkers and two foster parents.
- 4 Is there a difference in what may be expected of a child who grows into adolescence in a foster family and one who comes into a foster family at adolescence? Two foster mothers told us of their experiences with such children. In this meeting the matter of sex education was gingerly touched upon. The group felt that the whole matter of sex information and of the feelings that children and adults have about it should be left for "our course" next year on the younger child.
- 5 What were the recommendations of the financial planning committee? The report, given in two meetings, showed careful and critical scrutiny of the agency's plan of allowances as it related to the needs of children of the different age groups and their ability to take responsibility for the management of funds. For instance, the group challenged the agency's expecting a 6-year-old to set aside 5 cents a week to purchase a toothbrush periodically. At the same time they recommended that the allowance for the 16- to 18-year-old should

include 25 cents a week for dry-cleaning and 35 cents a week for haircuts. They did not feel that planning for shoe repairs should be left to the adolescent because this was an area of less concern to the adolescent and one, if neglected too long, would require additional expenditure by the agency. When the recommendations of the foster parents' finance committee was submitted to the agency board and became agency policy, another milestone in the foster parents' new-found status was passed.

6 The final discussion was on the displaced child.

Questions:

Why do foster parents choose to offer their homes to a European child?

Is the displaced child different from the American child, and if so, how, to what degree, and why?

Is treatment of him different from that given the American child? Or should it be? What are the differences in cultural background and how do they affect the child's adjustment to America?

What has the agency learned about the displaced child and can it apply that learning to the American child's needs?

What did these children expect from America, what did they find, and how did expectations and findings affect their behavior in the foster home?

A dinner meeting, held on the grounds of our institution, marked the end of this series of meetings. The program was planned by a joint committee of foster parents and staff. A member of our board and the Director of the Jewish Welfare Federation were present and addressed the group briefly. The rest of the evening was spent in informal parlor games involving everyone present.

Since then the annual dinner meeting has become a tradition to mark the end of each series of meetings. The genuine warmth and respect of the group members for one another, along with the plain good fun that characterizes that social affair gives us all a deeper understanding of the kind of people the foster parents are.

The summer months gave us an opportunity to gain some perspective on our foster parents' discussion program, to attempt critical scrutiny of what had been accomplished, and to

give consideration to what the future program should be. To be critically objective about something as vital, dynamic, and challenging as these meetings had been was not easy. Staff enthusiasm was untouched by the amount of time, thought, and energy that these meetings demanded.

It was clear to everyone that what was accomplished in these meetings could never be done in a person-to-person contact in individual situations. It was agreed that perhaps the most important purpose served by these meetings was the group feeling that had developed, and the recognition that had come to each of the foster parents of his role within the agency. All of us—foster parents and staff alike—were beginning to recognize a certain universality in the problems and reactions involved in foster parenthood. Foster parents and staff members alike began to recognize the uniqueness of their own special function. Foster parents were beginning to be recognized as the "experts" in the 24-hour day-to-day living with children, and caseworkers as the "experts" in the over-all knowledge of child development. The importance of mutual interchange became clearer to both.

What about the natural parents?

The staff recognized that a continuation of the program would involve further self-scrutiny and self-criticism. The way would be long and difficult for both worker and foster parent, because criticism is painful and the line between the destructive and the constructive is tenuous. But there was no question in the minds of staff as to the importance of continuing the discussions.

In the individual contact of worker and foster parent it would be difficult to say who was the more eager to apply the points that had been made. Each of our workers can tell of the foster parent's renewed desire to tackle the needs of the more emotionally deprived youngster, and of the worker's renewed confidence that this could be done jointly.

In setting up their discussion program for the third year, the foster

parents were still concerned with problems that make foster parents anxious. In choosing for their main topic of discussion, "The natural parents of the foster child," they were involved at first with the disturbing effect on a foster child of contact with his own parents, and with the resultant reaction on them as his foster parents. From a worker's presentation of the story of a family, the foster parents gained some understanding of what is involved for natural parents as well as for the children when it becomes necessary to seek foster-family care.

Perhaps a comment by one of the foster fathers will best illustrate what happened to many of the group. He said: "I used to think the agency shouldn't make it so easy for parents to place a child. I thought it was like taking off an overcoat and saying, 'Here, take care of it,' but I see it isn't so easy."

As the foster parents reluctantly and painfully permitted themselves to identify with the "own" parents, they also discussed their own feelings. They again tested out, and accepted, the freedom to talk about themselves. But certainly they were moving slowly toward understanding better a foster child's relationships outside of the foster home.

In their discussion of "frustrations"—the topic chosen for the third year—the foster parents considered all their experiences with the foster children which made them as parents feel frustrated. They found these frustrations in the foster child's behavior and reactions; in the accommodations they had to make in their own routines and family plans; in the existence of the foster children's own parents; in the foster child's relationship to their own children; in the uncertain and temporary nature of their relationship with the foster child; and in the limitations at times imposed by the agency policies. (This last was still to a great extent represented in the person of the caseworker.) In all this they were primarily concerned with their own discomforts. At the same time, however, they expressed some understanding of these frustrations as in-

herent in caring for a foster child. There appeared to be some further progress toward regarding their service as a defined job, with satisfactions, but also with problems that require adjustments in the performance of this job.

It was during this third year that many of the foster parents began to participate actively and effectively on a foster-home recruiting committee headed by a staff member. They derived real gratification from their feeling of status with the agency and in the community. It has been interesting to note that recent applicants for foster children have spoken of their interest in the agency's foster-parent discussion group.

Questions seem inexhaustible

The fourth year was devoted to a discussion of the relationship of foster parents to the agency: What are the qualifications for foster parenthood? To what extent are foster parents expected to modify their way of life and standards of behavior in order to accommodate the needs of the child? What are the agency's expectations of the foster parents in relationship to the child's own parents? And so forth.

The fifth year, just ending as this is being written, concerned itself with the following specific topics:

1. What is the relationship between the foster parents' own children and the foster child?
2. What responsibility does the agency carry for religious education, and what is the foster parents' part in this?
3. What is the role of the foster parents in sex education? (Three meetings were devoted to discussion of this topic.)
4. What is the attitude of the community toward foster parents and foster children?

During the 5 years that our monthly foster-parent meetings have been in progress, several things have become clear:

There has been a minimal turnover in placements.

Foster parents seem to be bringing to the job of foster parenthood the same attitude toward success and failure as do the rest of the staff; that is, there has developed an increasing reluctance to admit inability to care for a particular child.

There has been increased interest

in serving the difficult child and much greater involvement in cooperative planning with the caseworker in meeting special needs of various children.

There is greater identification with the agency as a whole and a clearer understanding of the foster parent's specific role.

The hitherto unobtrusive foster father has been drawn into active participation, not only in the group discussions but in the actual work with the foster child.

Word concerning our foster-parent meetings has permeated the community. This has been brought to our attention by foster-parent applicants who often refer to our meetings as one of the reasons why they would like to be a part of our agency's program.

We are finding, too, that foster-parent applicants have a much clearer conception of what is involved in foster parenthood than they did in the past. This, we believe, is a reflection of the community interpretation inherent in our foster-parent meetings and in our foster-home recruitment program, which is an integral part of our current agency program.

The status that foster parenthood has been gaining as far as the participating foster parents are concerned, has been manifold. One of our foster parents has written an article on what it means to be a foster parent, which has been published and reprinted for distribution by the Child Welfare League of America. This same foster parent has participated in panel discussions on foster parenthood held at conferences in Columbus and in Detroit. One of our foster fathers has drawn the pictures for a foster-home recruitment pamphlet which is being used community-wide by local child-placement agencies. Two of our foster mothers are actively involved in our foster-home recruitment program. Joint foster-parent and staff committees continue to reevaluate specific phases of the agency program. Our monthly foster-parent meetings are recognized by foster parents and staff as an inherent and indispensable part of our foster-home program.

understanding of the meaning of illness as a family experienced it. It was an eye-opener to become aware of parents' questions and attitudes that seldom would come to light during clinic visits. The planning group found it valuable to observe how a group approach could help families in adjusting to the child's illness.

A great deal was learned about team relationship through the process of working and planning together. This process carried through even in writing up the project. It was clear that the preliminary planning had been extremely important. The purpose of the project needed to be accepted and understood by the total group. This had to be a gradual process. Even with extensive planning, improper selection of parents could have defeated the goals of the project, since discussion depended on having a fairly homogeneous group. There was a feeling of purposefulness about the meetings and there was good group solidarity from the beginning.

The project demonstrated to the participants that there was value in having group meetings for parents of children with rheumatic fever. The planning group did not consider the results conclusive since tangible benefits for the parents could not clearly be defined. The experience, however, provided the staff with an opportunity to observe the potentials of the group approach as one way of helping families in their adjustment to the child's illness. The knowledge that the participants gained about parent attitudes, the opportunity the meetings provided to observe group interactions among the parents and their attitudes toward the clinic staff, the personal experiencing of the group process within the planning group, were unexpected by-products of the project. In retrospect, we see that the educational value to the staff may have exceeded the educational and therapeutic values for the parents.

This experiment has provided a basis for further study of the value to parents of group experiences in a rheumatic-fever program.

FOR YOUR BOOKSHELF

THE GROWTH AND DEVELOPMENT OF THE NEGRO IN DENTISTRY IN THE UNITED STATES. By Clifton Orrin Dummett. National Dental Association. The Stanek Press, Chicago, Ill. 1952. 124 pp. \$5.

It was a quarter of a century after the first dental school in the United States began its sessions that Robert Tanner Freeman, the first Negro in this country to receive a formal education in dentistry, graduated from Harvard University's School of Dental Medicine (1867). Since then, the author tells us, this school has graduated 25 Negroes, but the efforts of Negroes on the whole to gain opportunities for basic and dental education have met with much difficulty.

The book gives data on the ratio of Negro dentists to the Negro population at different periods from 1890 to 1940, and other important information, such as percentage increases and decreases of Negro dentists in various regions of the United States.

One chapter reports on a recent study of interracial professional practices and attitudes of Negro dentists in a Southern city.

While offering an interesting history of the Negro in the dental profession, this book also contributes to the literature on the development of dentistry as a whole in this country.

John T. Fulton, D.D.S.

HOME FINDING; the placement of children in families. By Gladys Denison Day. Federal Security Agency, Social Security Administration, Children's Bureau, Washington, 1951. Processed. 67 pp. Single copies free at Children's Bureau.

"Perhaps we can do a better job of planning new ways in the future if we spend a little time in looking at the mistakes we have made in the past." In these words the author shows her purpose in writing this objective appraisal of the social agencies' success, or failure, in finding foster homes for children.

"As social workers," she says, "we have failed to let the community know what we were doing and learning. A very small proportion of the public ever heard of foster-home care before the campaigns of recent years, and many people still know little if anything about it. This lack of information is largely the fault of professional workers who

have thought it possible to exist in isolation from the community."

The author discusses campaigns for finding couples who are likely to be suitable foster parents; study of foster homes; cooperative planning between the agency and the foster parent for the good of the child; and educational work with foster parents in groups. She also presents sample letters from an agency to foster parents.

Since the booklet is not intended to be a comprehensive study of the child-placing field, adoption families and independent boarding homes are not discussed; nor is casework with children in foster homes except as it affects parents.

Mrs. Day bases her study on long experience in child placing. She has been on the staff of the Children's Service Society of Wisconsin, the Chicago Child Care Association, and the Board of Public Welfare of the District of Columbia.

I. Evelyn Smith

IN THE NEWS

Rheumatic fever. The Board of Trustees of La Rabida Sanitarium, Chicago, announces the inauguration of an annual institute in the field of rheumatic fever. The institute will be held for the first time on October 12, this year, and thereafter on that date or the first Monday that follows October 12.

The institute will be educational in character and will cover the subject of rheumatic fever and rheumatic heart disease. It will be conducted for 4 days by members of the hospital staff, together with others selected from the medical schools with which the hospital is affiliated, and by several invited guests. It will be directed primarily to the general practitioner or family physician, and to nurses, medical social workers, occupational therapists, dentists, and others with a similar interest in the subject. There will also be a scientific session. Sessions will be provided also for the public, especially patients and their parents.

Advance registration will be required for those who wish to attend the entire 5-day session. Attendance will be open to all these groups and will be limited only by the size of the building to accommodate those who attend. Visitors to individual sessions will be admitted by card on previous application. There will be no admission or tuition charge.

Further information will be supplied by circular, on application to Institute, La Rabida Sanitarium, East 65th Street and South Shore Drive, Chicago 39, Ill.

Midcentury Committee. On July 1, 1953, the National Midcentury Committee for Children and Youth, which was formed late in 1950 to advance the findings of the Midcentury White House Conference, was dissolved.

Inquiries formerly directed to Leonard Mayo at 580 Fifth Avenue, New York City, should henceforth be directed to Dr. Katherine Bain, Acting Secretary, Interdepartmental Committee on Children and Youth, Children's Bureau, Department of Health, Education, and Welfare, Washington 25, D. C., or to Robert E. Bondy, Chairman of the Council of National Organizations for Children and Youth, 345 East 46th Street, New York 17, N. Y., or to Douglas H. MacNeil, Secretary, Council on State and Local Action, 222 West Main Street, Trenton, N. J.

Juvenile courts. A revision of juvenile-court standards to put more emphasis on the legal rights of children and their parents is being prepared jointly by the Children's Bureau, Department of Health, Education, and Welfare, and the National Probation and Parole Association.

As a part of the preparation of the revised standards, a group of some 30 experts in juvenile-court proceedings spent 3 days in Washington (June 17, 18, 19) going over a draft of revised standards. The experts included juvenile-court judges, probation officers, directors of voluntary and public welfare agencies, and lawyers.

The only previous formal statement of juvenile-court standards was issued in 1923—also made jointly by the Children's Bureau and the National Probation and Parole Association.

The revision will take into consideration not only the suggestions of those attending the conference, but also the suggestions of approximately 200 other persons who are leaders in the fields of law and child welfare.

The conference was presided over by Judge Edith Cockrill of the Juvenile Court of the District of Columbia. Karl Holton, Chief Probation Officer of Los Angeles County, California, was co-chairman.

The revision of the juvenile-court standards is a part of a larger program of the Children's Bureau to define good treatment practices in dealing with juvenile delinquency, for the use of professional groups. In process

of preparation also is a set of standards for training schools for delinquent children (no such document now exists), standards for police services to juveniles, guides to training of personnel who work with juveniles, and suggestions for State legislation on organization and coordination of services to delinquent children.

The program also contemplates preparation of information for the general public on certain aspects of the delinquency problem. Some of the pamphlets in this series already have been issued.

As drafted, the juvenile-court standards discuss the jurisdiction of the court, its procedures, the disposition of cases, court facilities and personnel, administration, records and plant, and the court's role in the community.

Mental Health. The Mental Health Materials Center, Inc., a new organization established for the purpose of developing new audiences and new distribution techniques for educational materials in the fields of mental health, family life, and human relations recently began operations with the aid of funds from the Grant Foundation.

According to its president, Walter Woodward, M.D., the Center's primary objective is to help the many organizations producing mental-health and family-life educational materials—printed and audiovisual—to reach new and larger audiences.

For further information address the Mental Health Materials Center, Inc., 1790 Broadway, Room 713, New York 19, N. Y.

Juvenile delinquency. A new Nationwide organization to combat delinquency was formed in June through a merger of the National Association of Training Schools and the National Conference of Juvenile Agencies. The new organization, named the National Association of Training Schools and Juvenile Agencies, will provide a vehicle through which all persons interested in group care of delinquent children can work to improve such care. Temporary headquarters is at Glen Mills Schools in Glen Mills, Pa. Raphael Farrell of the State Training School for Boys, Red Wing, Minn., is president of the new organization.

Cerebral palsy. "In a broad sense, a community effort" is the way the College of Physicians and Surgeons, Columbia University, describes the post-graduate course in cerebral palsy that it is offering this fall for physicians and occupational and physical therapists, under the sponsorship of the

Coordinating Council for Cerebral Palsy in New York City, Inc., and United Cerebral Palsy, Inc. For physicians the course covers 2 weeks; for therapists, 2 months. The opening date is October 12.

The course is designed (1) to acquaint potential leaders in this field with the basic knowledge concerning cerebral palsy; (2) to review the present status of practical therapy, including the medical, social, educational, and psychological aspects; and (3) to point out controversial features.

Cerebral-palsy centers in the New York area will cooperate.

For further information address Office of the Dean, College of Physicians and Surgeons, 630 West 168th Street, New York 32, N. Y.

C. B. PUBLICATIONS AVAILABLE

Single copies of the following publications may be had without charge by writing to the Children's Bureau.

The Children's Bureau Bookshelf; a book list for parents. Pub. 304. Revised 1953.

Children With Impaired Hearing; an audiologic perspective. By William G. Hardy. Pub. 326. 1952.

Emotional Problems Associated With Handicapping Conditions in Children. Pub. 336. 1952.

Children Living in Their Own Homes; social services provided through child-welfare programs. By Annie Lee Davis. Pub. 339. 1953.

Some Facts About Juvenile Delinquency. Pub. 340. 1953.

Helping Delinquent Children. Pub. 341. 1953.

What's Happening to Delinquent Children in Your Town? a guide for securing facts about certain agencies serving delinquent children. Pub. 342. 1953.

The Child With Epilepsy. Folder No. 35. 1952.

The Child With a Cleft Palate. Folder No. 37. 1953.

Services for Crippled Children. Folder 38. 1952.

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CALENDAR

Oct. 1-4. Rural Youth of the U. S. A. Conference. 9th annual meeting. Bloomington, Ill.

Oct. 1-5. National Conference of Catholic Charities. 39th annual meeting. St. Louis, Mo.

Oct. 1-31. Red Feather Month. Information from Community Chests and Councils of America, 345 East 46th Street, New York 17, N. Y.

Oct. 6-9. American Academy of Pediatrics. 22d annual meeting. Miami, Fla.

Oct. 8-9. American Council on Education. 36th annual meeting. Washington, D. C.

Oct. 12-17. Seventh International Pediatrics Congress. Havana, Cuba.

Oct. 18-21. Girl Scouts of the United States of America. 32d national convention (biennial). Cincinnati, Ohio.

Oct. 19-22. National League to Promote School Attendance. 39th annual convention. Washington, D. C.

Oct. 19-23. National Safety Council. 41st National Safety Congress and Exposition. Chicago, Ill.

Oct. 24. United Nations Day.

Oct. 28-30. National Legal Aid Conference. 31st annual meeting. Washington, D. C.

Oct. 28-31. National Association for Nursery Education. Biennial conference. Minneapolis, Minn.

Oct. 30-31. American Academy for Cerebral Palsy. 7th annual meeting. Fort Worth, Tex.

Oct. 31-Nov. 2. National Association for Mental Health. 3d annual meeting. Cleveland, Ohio.

Illustrations:

Cover, Philip Bonn.

Pp. 2 and 3, Lisel Lowen.

Pp. 7 and 8, Virginia State Department of Health.

P. 9, Esther Bubley.

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Published 10 times a year by the
Division of Reports, Children's Bureau

Editor, Sarah L. Doran

Art Editor, Philip Bonn

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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SOCIAL SECURITY ADMINISTRATION
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CHILDREN'S BUREAU
Martha M. Eliot, M.D., Chief

Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children.

The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau.

THE CHILD is sent free, on request, to libraries and to workers in fields concerning children; address requests to the Children's Bureau, U. S. Department of Health, Education, and Welfare, Washington 25, D. C.

For others the subscription price is \$1.25 a year. On all orders of 100 or more sent to one address there is a discount of 25 percent. Single copies 15 cents each. Send your remittance to the Superintendent of Docu-

ments, Government Printing Office, Washington 25, D. C.

Foreign postage—25 cents additional—must be paid on all subscriptions to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

THE CHILD is indexed in the *Education Index*, the *Quarterly Cumulative Index Medicus*, and *Psychological Abstracts*.

THE CHILD

OCTOBER 1953



UNITED NATIONS DAY, 1953

BY THE PRESIDENT OF THE UNITED STATES OF AMERICA

a Proclamation

WHEREAS the United Nations provides the peoples of the world with an organization through which international differences in the economic and political fields can be peacefully resolved; and

WHEREAS the need for the United Nations is greater than ever before, and its success depends on the extent to which its members give it support; and

WHEREAS the expression of our faith in and support of the United Nations will encourage and bring hope to the peoples of other nations who are also working toward a true peace with freedom and justice for all; and

WHEREAS the General Assembly of the United Nations has declared that October 24, the anniversary of the entry into force of the United Nations Charter, should be dedicated each year to the dissemination of information concerning the aims and accomplishments of the United Nations:

NOW, THEREFORE, I, DWIGHT D. EISENHOWER, President of the United States of America, do hereby urge the citizens of this Nation to observe Saturday, October 24, 1953, as United Nations Day by sending messages to friends, relatives, and associates in other member countries of the United Nations, by learning more about the United Nations and its members, and by expressing their confidence in the United Nations, their friendship for other peoples, and their faith in the ultimate triumph of peace and justice through the efforts of men of good will.

I also call upon the officials of the Federal, State, and local Governments, the United States Committee for United Nations Day, representatives of civic, educational, and religious organizations, agencies of the press, radio, television, motion pictures, and other communications media, and all citizens to cooperate in appropriate observance of this day throughout our country.

IN WITNESS WHEREOF, I have hereunto set my hand and caused the Seal of the United States of America to be affixed.

DONE at the City of Washington this thirty-first day of July in the year of our Lord nineteen hundred and fifty-three, and of the Independence of the United States of America the one hundred and seventy-eighth.



By the President:

A handwritten signature in cursive script, reading "Dwight D. Eisenhower".

A handwritten signature in cursive script, reading "Dean Rusk".

Secretary of State.



A MOTHER SPEAKS

Expectant parents want to be
briefed about childbirth

MRS. GEORGE W. GIBSON

MY REMARKS are made as a *consumer*, not a practitioner, of obstetric care. Please note the word I have used—*consumer*. That word is the key to a new way of thinking that is developing in the minds of young expectant parents in this country today.

When our grandmothers were expecting their babies, they approached this new experience with frighteningly little information. Because of their background, many of them didn't want to know much about the baby before he was born, didn't want to know how he was born. The doctor, who was consulted rather late in pregnancy, was usually a friendly despot. Grandmother did what she was told—like it or not—and she didn't ask questions.

The generation of parents to which I belong is different. War uprooted many of us just as we were coming of age. Our secure and stable home

life was shattered. Young men who had been cherished at home with admonitions to "put on your rubbers" and "don't forget your key when you go out" suddenly found themselves far from their homes—sent to all parts of the globe.

The Army and the Navy felt it was necessary and worth while to brief these men and carefully train them for the unfamiliar and rigorous experience ahead, for it was known that unprepared soldiers are likely to break down under combat conditions.

We parents of today want to be briefed for the experience of childbirth. We aren't satisfied with the old dictum, "The less they know, the happier they are," and we want to take an active part in the coming of our children. Having a baby isn't the same as having your appendix removed. It is a maturing and personal emotional experience, as well as a physical one. And it isn't a solo; it is a family affair.

A growing number of expectant mothers *and fathers* are eager to know exactly how their unborn baby grows, month by month; what labor is like and what feelings will be experienced; what the doctor and the nurse will do *and why*. We really think that this is due us as democratic members of society and as reasoning human beings.

It's the American way

It is a spirit which has pervaded other phases of American life for many generations. I have read that General von Steuben, one of the leading figures in the American Revolution, wrote this about Americans: "The genius of this Nation is not in the least to be compared with that of the Prussians, Austrians, or French. You say to *your* soldier, 'Do this,' and he doeth it, but *I* am obliged to say, 'This is the reason why you ought to do that,' and then he does it."

Nothing is more reassuring to an expectant mother than to know *why*—she can then obey the doctor's orders with confidence—but many of us may not really know just how to start asking questions ourselves.

Many doctors say to a woman embarking on her first pregnancy, "Now don't go believing all those wild tales your friends will tell you when they find you are having a baby."

That's very good advice, but it is negative. Why not tell us things that we *can* believe? Why should we come to the end of our pregnancy still in complete ignorance of routine hospital and delivery-room procedure? Why should we be delivered without knowing what happened during labor and birth? (All this could have been told us in a short time.)

Women who have had no preparation and who get no constructive help during this experience can be resentful and bitter, and rightly so.

The rising tide of demand for information is evidenced by the growing number of classes for expectant

Mrs. Gibson gave this paper at the fifth American Congress on Obstetrics and Gynecology, held at Cincinnati, Ohio.

parents throughout the country. When these classes are really well taught, and it amounts to a fraud if they are not, mothers and fathers approach the time of labor with confidence and true expectancy.

In addition, more and more parents are asking their doctors to take a more positive part and are expecting to be taught the facts, which will remove needless fears caused by ignorance. These consumers of maternity care know that some doctors become interested when they see real advantages for their patients and themselves. As a doctor said to me, "It's much more satisfying to care for a conscious, cooperative mother." And for such a mother, the satisfaction can be measureless.

I should like to remind you that since patients have begun to realize their prestige as consumers, a different attitude has sprung up among expectant parents about the selection of medical, nursing, and hospital care. In the usual buyer's market the consumer holds an economic power over the seller. A consumer compares competing products and services—the quality, price, and availability, and looks at both to see how well they meet his need. We consumers have been educated to do this choosing of medical care by the many articles

published in newspapers and popular magazines in the past few years.

Price is a concern of the consumer

The rising cost of everything, including medical care, worries people today. I know it is the concern of many doctors and hospital administrators. We consumers of maternity care recognize that the cost of obstetrics must go up as the cost of everything else goes up. We recognize that many of the new drugs and appliances that have made modern medical science so effective add to the cost, but we want to have our babies at a price that will not mortgage the future of our family. That's why so many young people are interested in the voluntary insurance plans to provide for hospital bills and at least a part of the medical fee. The more we join these insurance plans, the more economic power is being put into the hands of the consumer.

In former years a large majority of pregnant women went to the hospital or to the doctor expecting *not* to pay the full price. The clinics and wards were filled to overflowing with these. Such a woman waited her turn in a dingy clinic waiting room and heard herself referred to as "Case 234," instead of "Mrs. Biggs"; or she was called "teaching material" for

medical and nursing students. This was the price she paid for her care.

An increasing number of this large group today come for care under entirely different circumstances. They bring a certificate from an associated-hospital plan, or from some insurance plan that is company- or union-supported, which pays their bill. That is why I say they come as consumers, with increasing economic power. They no longer say, "Please help me." They say, "I have looked over the hospitals and have decided to come here."

Availability is also a concern of the consumer

For consumers of maternity care who live in large cities, the problem is chiefly one of selection—finding the best for the money they can pay. But a large percentage of the doctors certified by the American Board of Obstetrics and Gynecology live in or near our metropolitan areas. Most of our certified hospitals, too, are in the big cities, except the cities in the Far West where population has mushroomed in the last 5 years. In rural areas (and incidentally, it is here that a large proportion of the babies are born, as we all know) hospitals are miles apart, and to reach them you must travel over bad roads, often through mountains. There is no real security for mothers approaching the day of labor.

I wonder why more cannot be done to bring the existing services in the larger-population areas to people who live in less accessible places. In some localities libraries send their books to remote rural communities by bookmobile. There have been mobile grocery stores for years. In northern Canada and Australia airplane ambulances and radio bring medical care to families in remote areas. In some of these communities, a trained nurse-midwife provides care and instruction. The doctor on his periodic visits provides medical supervision and decides who among the women must be brought out by airplane ambulance to the hospital. In the mountains of Kentucky, the nurse-midwives of the Frontier Nursing Service go out to their patients on horseback.

In this case, quality for the consumer has to do with medical, nurs-

When a modern young couple seeks prenatal care, their obstetrician may be willing to explain hospital and delivery-room procedure. But they may not know just what questions to ask.



ing, and hospital care. Certainly I want, and I know every expectant parent wants, a doctor who is skilled and competent. We want to go to a hospital which meets the basic minimum standards set by the American Hospital Association. We who live in large cities are fortunate in being able to choose our medical care. Many people living in small or rural communities are not so lucky, and though

the rule book or is out of the ordinary. Change, in the highly organized routine of any institution—large or small—takes planning, effort, and first of all imagination to get started. But we all know that constructive change is vital in any field.

For instance, is there any good medical reason to pooh-poo a mother who wants to have her baby without deep anesthesia? And if she chooses

pitals have seen the value of changing this rule.

This same attitude toward the human side of maternity care has been shown by hospitals that understand the need for rooming-in for mother and child. The period right after a baby is born is a fine time for them to get acquainted. In fact, it may be about the only time a busy mother will get for a relaxed and leisurely acquaintance with the baby. And a good start in the hospital, where she can be getting to know him during the day and have her sleep at night, can encourage that love and affection that certainly will be needed after a mother goes back to an overcrowded and overworked home life.

Can't more hospitals adjust rules?

Using the words "leisurely acquaintance" reminds me of another point. A number of doctors have spoken up strongly about the need to reevaluate the importance of certain elementary hospital habits that interfere with the rest a patient needs. Is it really necessary to wake a mother who has just got back to sleep after nursing the baby, in order to have her temperature taken, or to be given fresh drinking water? Or to wash her hands, when breakfast will not come for an hour? Some of these things seem to be done very early in the morning because it is the job of the night shift to attend to them.

I know doctors and nurses are busy, and hospitals are complex institutions, but if some can consider the emotional and educational needs of expectant parents—why can't more? Business people on the whole have learned the advantage of being friendly to their consumers, and thoughtful of them. The president of a great corporation recently said in a speech, "The consumer is king," expressing in a verbal capsule what his company has found to be a practical truth.

When a baby is to be born the mother might well be considered the queen. Wouldn't everyone involved be happier and more satisfied if those who provide maternity care used im-

(Continued on page 29)



Having this baby has not mortgaged the future of the family. Through one of the voluntary insurance plans the hospital bill was paid ahead of time, as well as part of the doctor's fee.

much has been done to improve maternity care in this country, it is disillusioning to find there are today hospitals that don't provide proper services or live up to these standards.

But with the quality of maternity care still to be improved upon, there are other considerations that we consumers of maternity services would like to see seriously discussed.

All of us receive from time to time questionnaires from automobile manufacturers asking for suggestions for improving the comfort, roadability, or appearance of their product. Hotels politely ask us for suggestions for improving their services. We consumers of maternity care, however, sometimes find resistance when we express a desire for something that isn't in

to take her labor in this way, why shouldn't she get encouragement from those around her? It seems unnecessary that a mother should be repulsed and frustrated just at the time she should and can feel great personal accomplishment. Is there any good reason why parents and doctor can't sit down together and truthfully and honestly examine the facts? If a mother wants something that doesn't harm her or the baby, is there any good reason why she shouldn't have her way?

I also know that many expectant parents are disappointed when they are separated in the hospital corridor or at the door of the elevator. I know this is according to hospital rules in many cases, but a good many hos-

EMOTIONAL PROBLEMS AND THE C

ANNA L. PHILBROOK, M.D.

RESTORATION is at least as much a matter of spirit as of body, and must have as its central truth: Body and spirit are inextricably conjoined; to heal the one without the other is impossible. So said John Galsworthy.

This "central truth" is something we must act on in our work with crippled children if they are to get the most good from our technical skills. While we are treating a child for his crippling condition we need to help him develop his feeling of independence and his trust in his own basic strength and health.

One way to do this for a child in a hospital or convalescent home is to bring him what we can of his own world—his usual world of home, school work, and recreation, and whatever activities are suitable to his physical condition—and especially to

bring him the companionship of children of his own age.

Our efforts in this direction, besides tending of themselves to restore the child, are also—perhaps mostly—valuable to him as symbols of our acceptance of him, our concern for him as an individual, and most of all our belief that he is getting better and preparing to return to the world outside the hospital or convalescent home. All these activities should encourage him to continue his faith in himself and in us.

To help him uphold that faith, doctors, nurses, medical social workers, ward maids, and orderlies can all help by letting him feel their interest in him, not as a case of a fractured leg or a twisted foot, but as a person.

If we who are here to help the child recover his health forget him as a person, and are concerned only with techniques in doing our jobs, and if we become irritated with him when our techniques do not succeed, we put

a burden on him that may be more than he can bear. This is especially true if this burden is added to the pain he is suffering and his difficulties in adjusting to the hospital, which is so different from his home.

Unless we establish between the child and ourselves a relationship of liking and trust and mutual respect, our efforts to give him the care he needs may be wasted.

Look for emotional factors

Sometimes the doctor who is treating a child is unable to understand why the patient's condition is so slow in getting better.

If he studies the child's behavior he may find an answer to this question. For example, a 7-year-old boy, who had not wet the bed since he was 3 (as we learned from his parents), began to wet it persistently. He had been in the hospital for a number of weeks on account of a fractured leg. His bedwetting became so extreme that he had to be treated by a child psychiatrist. The psychiatrist did not find out what was at the root of the trouble, until, in the course of play therapy, the child placed a boy doll in a toy hospital bed. This brought on remembrance of a terrifying experience that he had had in the hospital.

One day, several weeks before, he had called for a bedpan; but before the busy ward maid could bring it to him, he had wet the bed. The maid became very much irritated, and told him if he ever wet the bed again she would throw him out of the window, which was six stories above ground.

After the psychiatrist heard this, she was able to help the little boy get over his terror and to accept the hospital conditions better. He stopped wetting the bed, and his recovery went ahead successfully. But even though the child's broken leg mended, it is clear that his emotional life was

Later in life the physically handicapped child will have to live among people who are not handicapped, and the younger the child when this adjustment is begun, the easier it is.



PLED CHILD

injured by his hospital experience.

It is of the deepest importance to a child who is physically handicapped—temporarily or chronically—that we do not become so concerned about what we are doing for him that we cannot see the child himself—his strengths and his personality. If we allow ourselves to be so concerned, we miss the main point of the treatment, which is to help the child to live the best life possible for him, within any limitations that he may have.

Patient takes part in treatment

This is part of the art of healing. Treatment springs not alone from the doctors, nurses, and medical social workers, but from the patient. Getting the best out of medical treatment of a crippled child requires (1) knowing the needs of the child; (2) helping him to fulfill as many of them as he can *himself*; (3) lending him strengths until he can fulfill others.

Such treatment is a matter of mutual understanding between the child and the adults who are trying to help him. When a child is encouraged, not only by hospital staff but also by his parents, to do his part as his condition permits, he is not likely to become "spoiled" through adults' overanxiety, as so many crippled children are in danger of being.

Sometimes a child who is under medical treatment for any kind of illness acts like a baby—doesn't want to feed himself, or otherwise seems to



While the doctor is treating a child for his crippling condition he is also helping that child to develop his feeling of independence and his trust in his own basic strength and health.

return to his earlier childhood. This is nothing to worry about if it lasts only a short time. And it is not likely to continue unless someone fosters overdependency in him. But we must not forget that continued overdependency may turn a child into a chronic invalid.

So we should not let the crippled child depend on us too much, but rather we should show him that we are aware of the force of health that is in him. Let us give that force a chance to strengthen itself; thus we can help the child gain its deep and rich reward.

In trying to help a handicapped child use his inner strength as he becomes ready to do so, we don't want to set him apart from other children, but neither can we ignore his handicap, which does make him different from them in a sense. Johnny, for example, cannot run as fast as the other children; Susie cannot hear as well; Jim cannot see as well. An intelligent child who is physically handicapped knows in what respects he is different from the others.

Some adults may try to give the child the idea that he can do anything the other children can do if he tries hard enough. Such forcing is as bad as the overprotecting that tries to keep him inactive instead of encour-

aging him to do what he is ready to do. Either forcing him or overprotecting him is likely to bring on decidedly unhappy responses, such as overaggressive, hostile, destructive behavior on the one hand and infantile behavior and overdependency on the other.

Study the child's individuality

Somewhere between forcing and overprotecting lies a constructive, realistic approach. And this begins by getting to know the handicapped child as an individual. We need to talk with him, to listen to him. We need not only to hear the story of his handicap, but to get a feeling of him as a personality, with assets as well as liabilities. Often the child gives us the cues himself, when he says, "You know I can't run and jump like the other kids, but I can draw." We listen seriously and say, "Yes, it's true; you're right, and there's much more to life than just running and jumping."

If a child of average intelligence is not forced or overprotected, he will find his place among other children. And we adults might better let him do it rather than trying to do it for him or making excuses for him. Unless we push him too far or too fast, or stop him from trying himself out

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Dr. Philbrook based this article on a paper that she gave at the 18th New England Health Institute, held at Storrs, Conn.

with his own group, he will soon begin to know his strengths and limitations. We can encourage and help him to do this, but we cannot do more, and should not attempt it.

And while he is learning about himself, we too can get to know him, and can help him to bring his assets to the fore and to strengthen these assets. We can help him learn in every possible way to care for himself.

It is not only workers with special knowledge regarding handicapped children who can help such children to become independent; teachers and

and sisters, for his return. They will ask questions about what this handicapped child can do, and we must answer their questions as clearly as we can.

We all know that many parents feel guilty if one of their children is physically handicapped. Some of them express this feeling by blaming someone else for the child's difficulties. And if time and attention are not given them to let them talk about this, they may fiercely defend the child and thus lead him into blaming the doctor or some one else. This may

his condition, the child is likely to settle down as just another member of the family, with a good chance to be emotionally stable. Help of this kind can be given by a crippled children's worker who is willing to spend time not only with the parents, but also with the family doctor and the child's teacher.

A child needs his own people

If a crippled child's home is not a healthful place for him, either physically or emotionally, we should make every effort to help the parents improve the home before we take the extreme measure of planning to place him in a foster home. If it is decided, however, to place the child in a foster home, it is our duty to help the foster parents to understand the child's special needs and his special capabilities.

But whatever the place where the child is to live, it is not realistic for us to separate him from children who are not physically handicapped for any time longer than is absolutely necessary. Later in life he will have to live among people who are not handicapped, and he can learn to make this adjustment much more easily in childhood than when he is older.

In this article I have not discussed preparing the child ahead of time for going to the hospital because much has been published lately on that subject. But help given ahead of time, provided by specially trained workers, is of vital importance for it helps the child and his parents to mobilize their inner resources to meet the difficult hospital experience—not only the child's pain and fear, but his separation from his parents. And we who work with crippled children should help to prepare not only the child, but the parents, and also the family doctor who is going to take care of him when he returns.

Throughout this whole experience—the preparation, the hospitalization, and the difficult time after the child's return home—he needs to be helped by people whom he can trust, who treat him as an individual with strength and health in him.



This little girl attends classes regularly in the convalescent institution where she is staying. Doing school work helps her to realize that she is part of the usual world of childhood.

parents can learn to do the same. And the specially prepared workers need to convey some of what they themselves have learned to the teachers and parents who will be close to the child every day.

This brings us to one of the most important steps that the staff of a hospital or convalescent home can take in guiding a handicapped child; and that is to get him back into his own home as soon as possible. Even if that home seems to us inadequate, it may fulfill his need for love.

But before we send him home we must take the time to prepare his father and mother, and his brothers

result in alienating the child from those that could be helpful to him.

Parents sometimes manage to combat their feeling of guilt by making the crippled child the center of the home and ignoring the other children. This, of course, is likely to injure the crippled child doubly. First, it may turn his sisters and brothers against him. And secondly, he is likely to grow up expecting everything to revolve around him; when things do not come his way he feels that people are against him.

When a crippled child's parents are helped to accept him as he is, with his limitations, and not feel guilty about

SO THAT CHILDREN MAY REMAIN IN THEIR OWN HOMES

Homemaker service strengthens Aid to Dependent Children program

ELIZABETH G. WATKINS

ILLINOIS' program for Aid to Dependent Children, which has been in force in the State for more than a decade, has enabled large numbers of needy children to remain in their own homes and to receive care and supervision from a parent or other close relative. (Aid to Dependent Children, under the Social Security Act, may be granted when a parent is dead or disabled or continuously absent from home.)

The ADC program is based on the premise that a child develops best in his own home, with his own family, and as a rule he is damaged if separated from his own people. To prevent such damage it is essential that children are not unnecessarily removed from their home, even temporarily, and that the family group is maintained with as little change as possible.

But what happens when illness strikes the mother or whoever is caring for the children? Or if for some reason other than illness the person in charge has to be away for some time? These are questions that must be faced by any public agency charged with administering the ADC program. Some plans must be made for caring for children when this situation arises; otherwise families that the program is trying to hold together will be broken up, and the children placed in foster homes or institutions.

In Chicago, the Public Assistance Division of the Cook County Department of Welfare, which administers the program, recognized this need soon after Illinois put ADC in force.

Then, as now, efforts were made always to utilize resources within the normal range of family relationships. The agency would help the family to

use its own resources—to ask a relative, or a friend of the family, or a neighbor either to stay with the children or to take them into her home temporarily. Unfortunately, such resources are not always available; and reliance on them sometimes results in arrangements that are haphazard and unsatisfactory. Besides, such resources were particularly lacking in Chicago during those days of major defense activity, when large numbers of women were employed, many homes were overcrowded because of housing shortages, and family living was subject to abnormal strains and tensions.

The Public Assistance Division therefore decided to set up a plan that would make it possible for these families to remain together through employment of a homemaker. Under such a plan the agency would place in the home a woman chosen for her skills in homemaking and her ability to work with children, as well as grown people, and to adjust to various situations. This woman would care for the children and the home during the time when the mother was temporarily unable to do so.

The first step was to explore community resources through which skilled homemakers might be obtained. Some of the private family-service and child-care agencies had well-established homemaker programs. These services were limited, however, and generally were not available for extensive use by other agencies.

The public agency administering general relief (the City of Chicago's Department of Welfare) also had an excellent homemaker program, which had developed from a WPA training project. An arrangement was made with this agency whereby homemaker services were purchased for families

receiving Aid to Dependent Children. Not enough homemakers, however, were available to meet the demands of both agencies. Besides, problems of dual supervision arose, as well as some technical complications involving division of responsibility for compensation in case a homemaker should be injured on the job. Since the difficulties could not be satisfactorily resolved, the arrangement for sharing homemaker services was terminated. This again left the Public Assistance Division without a resource for trained homemakers.

The need for homemaker services was increasing, and it became more and more apparent that the best solution would be to develop a homemaker program within the Public Assistance Division. Other plans, however, were given considerable thought, including establishment of a homemaker service agency which would be a resource for

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Mrs. Watkins received her master's degree in Social Service Administration from the School of Applied Social Sciences, Western Reserve University, and has done subsequent work at the University of Chicago and the Institute for Psychoanalysis, in Chicago. She has been with the Cook County Department of Welfare for over 15 years in various consultative and administrative capacities.

The paper from which this article is condensed was presented by Mrs. Watkins at the 80th annual meeting of the National Conference of Social Work, held at Cleveland.

During the years 1942-52, the program for Homemaker Services in the Public Assistance Division of the Cook County (Ill.) Department of Welfare was evolving. The Division realizes that this discouragingly slow development was not a unique process, but one which may be faced by other agencies concerned with the establishment of such a service. Therefore, some of the details of the development of the program are presented here, in the hope that the story may encourage agencies that are having similar struggles, inasmuch as eventual establishment of the service is a real and gratifying compensation.

the entire community and would provide services to other agencies on a fee basis.

Progress slow

Discussion of this and other plans went on for several years. During this time the agency provided *housekeeping* service as a substitute plan.

When housekeeping service is used the responsibility for obtaining the housekeeper rests with the family, although the agency may assist in locating the proper person. For the wages of the housekeeper, an allowance is included in the assistance grant. Wage standards for this type of service have been established by the agency, which also maintains control of the amount of service to be provided to a family.

Under certain circumstances housekeeping service may be useful; for instance, when a mother is competent to select and supervise her own help, when she feels her position as a mother is less threatened by a housekeeper than by a homemaker, or where the needs are primarily for domestic service. Although such a plan is useful in some instances and is still relied upon where it can be used appropriately, it does not always meet the situation adequately.

The most serious problem in this type of service is that of assuring the quality of the service, which is difficult when the agency is not responsible for selection, training, and supervision of the persons employed. Payment presents another difficulty. Wages are the responsibility of the family, and so payment cannot be assured by the agency. Most of the difficulty arises, however, from the slowness with which money for this purpose can be made available to the family. A complicated assistance-roll procedure usually necessitates a 3-week span in the processing of assistance checks. Housekeepers expect payment promptly upon completion of an assignment and are exceedingly distressed if forced to wait for 2 or 3 weeks, or even several days.

Homemaking service, provided through a carefully selected, trained, and supervised staff, paid by the

agency, obviates many of these difficulties.

Finally, in June 1952, the Illinois Public Aid Commission, which administers the ADC program, authorized the Cook County Department of Welfare to establish a program for homemaker service in its Public Assistance Division. The Commission also obtained approval for Federal participation in the plan. The homemakers were to be employed only in the program for Aid to Dependent Children. Owing to limitation of funds, only 20 positions could be established; and because there were so few homemakers in relation to the need for them, their services were to be given to a family for only short periods—not more than 90 days for one family.

No change was made in the basic criterion for placing homemakers, that is, temporary need for care and supervision of children when no relative is available to give such care.

The first major step in initiating the homemaker program was to select personnel.

The supervisor who was selected is a woman who formerly supervised a district office of the Public Assist-

ance Division. She has a master's degree in social-service administration and a rich background of both casework and administrative experience. Working with her as field supervisor of the homemakers is a woman who has a degree in home economics and who has had graduate work in a school of social service and several years' experience as a caseworker in the Aid to Dependent Children program.

The homemakers were recruited from three groups: (1) from mothers who were themselves receiving grants under the Aid to Dependent Children program, but who were able to arrange adequate care and supervision for their own children during working hours; (2) from women who had formerly been employed in the homemaker program of the General Assistance Division of the City Department of Welfare and who had served satisfactorily; and (3) from women who had been previously employed as housekeepers under the ADC program and had given excellent service.

In screening applicants, the agency's Homemaker Services and its Vocational Counseling and Placement

Demonstrations of child care are given as part of a training course for homemakers.



Services collaborated closely. A screening interview was held with each applicant, which focused on her availability for work, her attitudes, her interests, and her social background. Besides, each applicant was required to take a thorough physical examination before the final decision was made. Women who successfully completed those preliminary stages were certified by the County Civil Service Commission as temporary employees of the Cook County Department of Welfare and were given training that covered a period of 2 weeks, 8 hours a day.

Any agency providing homemaker service would deal with a wide variety of situations in which homemakers are needed. In a very large public agency the range is so wide that the homemakers must be very adaptable and flexible. Also, in view of the relatively small number of trained homemakers available, the agency must face a rather difficult problem in selecting the families to benefit from their skills. Not only is a homemaker needed when the mother is absent from home, or when she is too ill to function as usual even though she remains at home. A homemaker is

needed also in a variety of other situations, such as when a mother knows so little about housekeeping that the agency that is trying to help her feels that it would be better to delay any work with her on her other problems.

Such a mother was Mrs. Jones, who, with her 11 children, had been evicted from an apartment in a Chicago Housing Authority project because of her low housekeeping standards and her consistent failure to comply with the Authority's rules and regulations.

Mrs. Jones' behavior had seemed so antisocial, in relation both to many people in the community and to the Housing Authority's property, which she abused, that various agencies involved in her eviction (with a subsequent family "sit-down strike" in the Mayor's office) had questioned her adequacy as a parent. They had even recommended that a referral be made to the juvenile court for placement of the children.

Instead, because Mrs. Jones desired to obtain adequate housing for her family in a public-housing project she agreed that a homemaker might help her to learn to do a better job of making a home for her children. In

the meantime she and her children would live in temporary quarters in a relocation area, with the expectation that they would be permitted to move into a Housing Authority project later.

The agency assigned a homemaker to the Jones family on the basis of her technical skills, her ability to take part in the household without threatening the relationships between the mother and the children, and her understanding of her function as part of a casework plan. She remained with the family for 3 months, working 5 days a week, 8 hours a day. During this time she helped Mrs. Jones in assessing the family's minimum need for items of household equipment and supplies, selecting them, and buying them. The mother was taught to care for furniture and equipment, to plan menus, to buy food, store it, prepare it, and serve it, and the other basic skills that are necessary in managing a household.

Mother's capabilities revealed

Perhaps the most important contribution Mrs. Jones brought to the plan was a determination to learn the things that had not been part of her deprived and insecure childhood and married life. Her lack of knowledge was staggering, but the homemaker had unlimited patience and understanding. Within 2 months it was clear that Mrs. Jones was capable of carrying her household responsibilities. What was much more important, she showed that her strength as a mother was such that her children should not be taken away from her.

In terms of agency expenditure, this case represents a large investment of casework and homemaker service. The field supervisor of homemaker services visited the Jones home weekly for the duration of the assignment. The caseworker, besides visiting the home frequently, held numerous conferences with the homemaker field supervisor, the agency's home economist, and its casework consultant. At interagency conferences the family's progress was studied and their problems analyzed in relation to their housing needs, to health and social factors, and to the children's adjustment in school.

At a regular meeting held by the agency, homemakers discuss meal planning and nutrition.



As a result of all this, the Jones family—a mother and 11 children—has discovered its potential for stability and for normal family and social adjustments, and has been strengthened thereby.

My other story illustrates the use of homemaker services in evaluating the possibility of keeping children in their own home even though the relative in charge of them felt that she could not take care of them properly and was requesting that they be placed elsewhere.

Mrs. Brown, in her early fifties, not very strong and with very poor sight, was receiving grants for Blind Assistance and also for Aid to Dependent Children; she was caring for her four orphaned grandchildren, aged 2, 4, 5, and 10 years.

After the children's mother died, the grandmother had attempted for more than a year to care for them, with some help from relatives. The relatives, however, had never given real and sustained help, and Mrs. Brown had finally decided that it would be best for the children if they were placed in foster homes.

In discussing her decision with the caseworker, Mrs. Brown showed conflicting feelings, and seemed relieved when the caseworker suggested that a homemaker go into the home to help her, pending further consideration of the plan for placing the children. Mrs. Brown agreed that she needed help not only with the housekeeping and marketing but with supervising the children.

First: a cleaner house

The homemaker assigned to the Brown family was a cheerful, maternal woman, who was placid and gentle in her approach to people.

Soon Mrs. Brown was impressed by the greater cleanliness of her house. She had worked hard to keep it clean; but her very limited vision, plus her lack of physical strength and the demands of four active young children had kept her from living up to her standards of household neatness, which were high.

Help from the homemaker in shopping for bargains and in meal planning eased the strain of money management; and in a few weeks

Mrs. Brown began to feel that perhaps it would be best for the children to remain in her home, where they really belonged and where they could have their grandmother's love and concern.

During this time one of the children fell critically ill, and Mrs. Brown, with the help of the homemaker, took care of the sick child calmly and competently. This crystallized her determination to keep the children with her. With this decision made, it was clear that the homemaker's job had been successfully completed; and Mrs. Brown entered actively into planning with the caseworker for a part-time housekeeper to help her with the actual housework. Having learned while the homemaker was with her how to manage and still relax, Mrs. Brown displayed a serene confidence in her ability to handle the home and the children.

Feeling of adequacy encouraged

The lack of help from the other relatives and their diminishing interest in the welfare of the children had made her hostile toward them, and, although she did not realize it, this hostility had been transferred to the children. This had caused her to feel overwhelmed by her problems and had blocked her love and acceptance of her grandchildren.

The presence of the homemaker had temporarily relieved Mrs. Brown of the pressures of the physical aspects of housework and child care and had enabled her to analyze her relationship with the children in terms of family strengths and values. Fortified by the contribution of the homemaker, Mrs. Brown was able to plan to maintain a home for the children, with the kind of help that she needed on account of her visual handicap—help that did not lessen her feeling of responsibility and of adequacy in caring for her grandchildren.

This experience with a homemaker and a housekeeper demonstrates, in a practical way, a method of keeping children in their own home.

This agency, like many other public agencies, has to face certain weaknesses in the administration of its service program, due to the size of

caseloads and the shortages of trained personnel.

For example, when a family is being prepared for the coming of a homemaker, the preparation varies with the skill and understanding of the caseworker and the amount of time she is able to give to keeping in touch with the family. In many instances plans for homemaker service are made by caseworkers to whom the children in the family are little more than names on a form. Individual differences in children as personalities seldom are recorded, and are not known to the harassed caseworker unless some child has such serious problems that recognition of them is forced upon her attention.

This difficulty also hampers preparation of the homemaker for going into the family home. Forms for referral from the caseworker to the supervisor of homemaker services are planned to provide the latter with data about the family, which the homemaker needs to know. These forms have space for information on the family's physical environment and its health and social problems, as well as for detailed budgetary data. On the basis of this information the supervisor selects a homemaker for the family and prepares her for her assignment.

Homemakers face difficult situations

This plan, on the surface, appears sound and practical; but in view of its purpose as a step toward helping human beings it is meager. For example, the referral may describe Mrs. Smith as a "dull woman," whose home is "untidy," and whose children appear to be "somewhat neglected." But when the supervisor and the homemaker become really acquainted with the home of the Smith family, they may find that the form has understated the case. They may find the mother seriously retarded in mentality, hostile, suspicious, quick to feel threatened, and terrified by superstitious foreboding about her impending hospitalization. The children who were described as merely "somewhat neglected" may never have been toilet-trained, may never have learned to eat their meals at a table, and may never have had a

whole bath since they were babies. The "untidy" house may not have been scrubbed or deverminized for years.

Many serious problems that have not been apparent to the caseworker during her regular visits to the family to determine its continuing eligibility are evident to the homemaker before she completes her first day in the home.

The lack of information does not imply that any worker has failed in her duty. The situation is inevitable when an agency must place primary emphasis on redetermination of the family's eligibility, and staff has insufficient time to devote to the recognition and treatment of social problems.

Our homemakers have shown that they can cope with the shock of going unwarned into the most deteriorated physical surroundings. But some of the social and emotional problems they encounter, which have been scarcely conveyed to them ahead of time, test to the utmost their warmth, flexibility, and patience.

If the families that need a homemaker are to receive the greatest possible benefits through her skillful help it will be necessary to provide, through field supervision, a combination of functional supervision of the homemaker and liaison services between the homemaker and the caseworker. This should help to interpret to the homemaker her role in the casework process and should assist her in understanding and maintaining the type of relationships appropriate to the specific situation.

The initial phases of any service usually reveal extremes in positive and negative factors. This has been true during the first year of this homemaker program. The most important values, however, are those which cannot be assessed so soon.

Only time will tell

After a decade of experience passes, an evaluation of the homemaker program should produce an accurate assessment of its values, both tangible and intangible, as evidenced by the kinds of adults who have developed from the children whose homes and family life have been fortified by homemaker service.

A MOTHER SPEAKS

(Continued from page 21)

agination, sympathy, and the human touch? Wouldn't the consumer be more responsive and cooperative? Delivering the mother of a baby may be a *business* for doctors and nurses but it can be a fascinating and exciting experience for both mother and father if those who provide the care do so with a friendly manner and a few simple explanations. We mothers are human beings and not just the bases for medical charts.

I am fully aware of the great changes for the better that have been made in many minds and in many places. When our son was born not long ago in a hospital, I was aware of a real spirit of cooperation between the doctor, the nurses, and myself. I had a great sense of being included as part of the team, and I was granted full recognition of the helpfulness of my prenatal training and preparation. It was a marvelous experience, and I was not a unique case; but I know it is not a universal experience and I think it can be.

I was talking recently to a nurse who had just returned from a Scandinavian country. She said that there doctors, nurses, and patients seem to be on a mutually friendly and intimate basis. They seem to understand one another and each tries to cooperate with the other. We in this country are not ones to admit that what can be achieved in one country cannot be done here. I think it's something to work for.

We consumers are not unreasonable. We know that maternity care is a service that is not easily individualized. I know some doctors and nurses will say, "You don't expect me to take time to cater to every mother's every whim." No, of course I don't, but I do say, in the words of one of Bing Crosby's hit songs, "Accentuate the positive." We can accentuate the positive when doctor, nurse, and consumer talk to one another and say the things that are truly on their minds. It is only as this is done that democracy can bring satisfying services to the women who bear the future of America—its children.



Nov. 4-7. Association of State and Territorial Health Officers. 52d annual meeting. (With the Surgeon General of the Public Health Service and the Chief of the Children's Bureau as well as State Mental Health Authorities and representatives of State Hospital Survey and Construction Agencies.) Washington, D. C.

Nov. 8-11. National Conference of Christians and Jews. 25th annual meeting. Washington, D. C.

Nov. 8-13. American School Health Association. 27th annual meeting. (With American Public Health Association.) New York, N. Y.

Nov. 8-14. American Education Week. 33d annual observance.

Nov. 9. Association of Maternal and Child Health and Crippled Children's Directors. 11th annual meeting. (With American Public Health Association.) New York.

Nov. 9. Play Schools Association. 14th annual meeting. New York, N. Y.

Nov. 9-13. American Public Health Association. 81st annual meeting. New York, N. Y.

Nov. 10-13. American School Food Service Association. 7th annual convention. Boston, Mass.

Nov. 11-13. National Association of Intergroup Relations Officials. 7th annual meeting. Minneapolis, Minn.

Nov. 12-13. National Social Welfare Assembly. 9th annual meeting. New York, N. Y.

Nov. 12-14. National Council of Negro Women. 1st biennial convention. (Previously the Council met each year.) Washington, D. C.

Nov. 12-14. National Society for Crippled Children and Adults. 30th annual convention. Chicago, Ill.

Nov. 13-20. American Occupational Therapy Association. 36th annual conference. Houston, Tex.

Nov. 15-21. National Book Week. 35th annual celebration. Information from Children's Book Council, 50 West 53d Street, New York 19.

Nov. 23-25. American Speech and Hearing Association. 29th annual convention. New York, N. Y.

Area conference, National Child Welfare Division, American Legion:

Nov. 5-7. Area E—Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming. Portland, Oreg.

• FOR YOUR BOOKSHELF

THEY LEARN WHAT THEY LIVE: prejudice in young children. By Helen G. Trager and Marian Radke Yarrow. Harper & Bros., New York. 1952. 392 pp. \$4.50.

Someone has said, "Prejudice is being down on something you are not up on." The authors of this pioneer study, based on sample populations from four Philadelphia public schools, prove that children 5 to 7 years of age, can, like adults, be down on ethnic groups whose characteristics they fail to understand. Like their parents and their community they reject chiefly Negroes, then, in order, Jews and Catholics.

What happens when the young child enters school with natural curiosity and friendliness but also with this confused freight of incipient stereotypes and prejudices? Generally he is taken in hand by teachers who themselves are cut in the pattern of the community and are unaware of either the dynamics or the dangers of prejudice. In many instances the teachers merely reinforce the hierarchical view of the occupational and ethnic layers in American society.

Probably it is too much to expect teachers to counter the heavy pressure of parental and social norms. Yet by virtue of a well-conceived and well-executed "change experiment" this Philadelphia Early Childhood Project was able to show solid effects from a 14-session program in intercultural education with first- and second-grade children. First the teachers were trained to play two contrasting roles, i. e., to teach two classes of children by two different methods. One method stressed the "cultural monism" of American society, accepting stereotyped judgments, and permitting children to believe that "the way things are" is eternally the right way. Deviants in our culture, the children were allowed to believe, may properly be regarded as "funny." While this method did not deliberately indoctrinate the children with prejudice, and is probably no worse than what children normally are exposed to, yet the reader squirms a bit to read about its deliberate use even for experimental purposes.

The other method stressed "cultural pluralism," bringing the child to see that each occupation, each religion, each race, has a valid part to play in the diversified life of the community. (The detailed curriculum of

the 14 sessions for both types of teaching is itself a notable contribution, and will interest all workers who deal with 6- and 7-year-olds.) Good controls were used in the experiment, thus enhancing our confidence in the results. It turned out that children trained in "cultural pluralism" showed much less stereotyping and much more friendliness toward minority groups at the end of the experimental period than did children in "status quo" classes.

Perhaps the most remarkable achievement was leading teachers to play the required roles, to master two styles of pedagogy. Their own gain in insight and in democratic attitudes is striking, more striking than the children's because they are older.

A quarter of the volume is devoted to the experiment. The remainder is somewhat anecdotal, setting the scene in the children's homes, community, and school. Numerous quotations from the children spice the pages and make them easy to read.

The study emphasizes perhaps too heavily the mental content (beliefs) that children, teachers, and parents have. What is missing is the *why* and *how* of learning. What, for example, is the effect of strict punishment in the home or school upon the development of prejudice? Does home discord engender insecurity and this in turn lead to fear and distrust of minority groups? We learn little of the reasons for marked individual differences among children: some seem benign and trustful from the start; others are hostile and vindictive in spite of the skillful intercultural training. But these problems may be left to other researchers.

Prejudice is exceedingly complex in its psychological and social causation. It is more than enough that the authors have illuminated the issue as it relates to teacher and child in the first years of school.

Gordon W. Allport, Ph. D.
Harvard University

UP YOUR ALLEY. By Lazelle D. Alway. National Child Labor Committee, 419 4th Avenue, New York 16, N. Y. Publication No. 410. 1953. 31 pp. Single copies free. Quantity rates on request.

Job conditions under which boys work as pinsetters in bowling alleys, as reported on questionnaires completed by 460 boys, are described in this pamphlet. The boys' answers point to the moral hazards to which young pinsetters may be subjected

through association with the drifters and delinquents with whom they work.

The pamphlet tells about the pressures resorted to in order to continue employment of under-age boys and the results of this pressure on child-labor legislation in various States. It also suggests to bowlers, parents, proprietors of bowling alleys, and other interested citizens ways in which communities can find out about the situation in the bowling alleys in their towns, and can work to remedy abuses.

Miriam Fuhrman
U. S. Department of Labor

REMINDER SHEETS FOR EXERCISES IN PREPARATION FOR CHILDBEARING. Maternity Center Association, 48 East 92d Street, New York 21, N. Y. 1953. \$2.50 per set; \$2 in lots of 25 or more.

This is a set of 32 sheets of black-and-white line drawings showing exercises to be used in connection with classes in preparation for childbearing. Each drawing (there are 86 in all) has a caption explaining the exercise.

The set comes in a sturdy manila folder, on which there is a foreword explaining that the sheets are to be given to the mothers, so that when they get home they will have a reminder of what they have been taught in class. A few principles concerning exercises and hygiene of pregnancy are given.

On the folder also is a briefly annotated list of suggested reading material for expectant parents.

Enclosed in the folder with the sheets is a 5-page mimeographed article that describes the content framework of the Maternity Center Association's classes in preparation for childbearing.

Although the Reminder Sheets were designed for pregnant women, they depict plain, everyday good body mechanics and might well be used also by other people.

Margaret W. Thomas, R. N.

CHILD ADOPTION IN THE MODERN WORLD. By Margaret Kornitzer. Philosophical Library, New York. 1952. 403 pp. \$4.50.

England had no adoption law until 1926. Previously people who took a child into their home were unable to give him any legal status; he was merely a foster child. Adoption in England during the quarter century since then is the main subject of Miss Kornitzer's book, though she also tells

much about adoption in other countries of the British Commonwealth, in European countries, in Latin America, and in the United States.

The book indicates many similarities in adoptions in England and in our own country. It also notes some differences. For example, in this country the usual procedure is that a child born out of wedlock or of a previous marriage is adopted by the natural parent's husband (or wife), with the consent of the spouse. In England, on the other hand, a natural parent may adopt his or her own child, either alone or jointly with the marriage partner.

In both countries, the number of families applying to adopt children far exceeds the number of children available. Also, both countries have the problem of adoptions arranged by individuals instead of by registered, or licensed, adoption societies.

Of interest to families in this country that are interested in adopting an English child is the fact that a child may not leave England for adoption by aliens unless they are relatives. Also, a British citizen living abroad who is not the child's guardian or a relative can adopt him only by license obtained at a special court hearing.

The author deals with the roles of the different parties involved in an adoption (the natural parents, the child, and the adoptive parents), points out the legal processes necessary in England, goes into the problem of telling the child that he is adopted, and takes up the placing of difficult and "unadoptable" children.

In discussing adoption in the United States the author places what is probably too much emphasis on the "black market" in babies, in view of the relatively few cases that would fall in this category.

A bibliography is included, and a list of registered adoption societies in England, Wales, Scotland, and Northern Ireland.

I. Evelyn Smith

NURSERY SCHOOL PORTFOLIO (12 leaflets). Association for Childhood Education International, 1200 15th Street NW., Washington 5, D. C. General Service Bulletin No. 1. 1953. 75 cents; 20 percent discount on orders of 25 or more. Individual leaflets, 10 cents; discounts on quantity orders.

This entirely new version of the former "Portfolio for Nursery School

Teachers," which was published by the Association for Childhood Education International in 1945, is "a replacement rather than a revision." It will be welcomed by many friends of children in addition to those intimately concerned with nursery schools and day-care centers. The leaflets that make up the portfolio cover much of the basic philosophy of fulfilling preschool children's needs, and do it in a fresh, vital way, with dozens of real-life illustrations.

What to expect of children at different age levels, what constitutes a good nursery-school day for 2- and 3-year-olds and for 4-year-olds, guiding the young child's play, science experiences, and music all come in for discussion; as well as housing the nursery school, and records and reports.

The leaflet on the cooperative nursery school will be helpful both to parents and to workers who are called on to explain the difficulties and dangers of parent cooperatives, as well as their significant advantages.

The 10 contributors, who worked under the chairmanship of Myra Woodruff of the New York State Education Department, are well-known in the field of nursery-school education.

Marion L. Faegre

EMPLOYED MOTHERS AND CHILD CARE. U. S. Department of Labor, Women's Bureau. Bulletin 246. Washington. 1953. 92 pp. For sale at 30 cents by the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

Based on a 1951-52 field study conducted in 28 towns and cities where there has been a marked industrial expansion, this bulletin sets forth the situation in most of these localities with regard to day-care facilities for children of working mothers.

In the United States as a whole employment of mothers between the years 1940 and 1950 at least tripled. In the year 1940 1 out of every 9 women in the labor force (employed or seeking employment) were mothers with children under 18, whereas in 1950 the ratio was 1 to 4. In 1951 nearly one-fourth of all mothers with children under 18 were in the labor force.

The bulletin states that day care for the children of these mothers has become an important consideration for most industrial communities, with evidence in all localities visited that the great and probably growing need is as yet far from being met.

Mildred Arnold

THE CHILDREN'S BOOKSHELF; a booklist for parents. Federal Security Agency, Social Security Administration, Children's Bureau. CB Pub. No. 304. Washington. Revised 1952. 56 pp. For sale at 20 cents by the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Single copies available from the Children's Bureau without charge.

Many of the books listed here are very inexpensive, although they were not chosen for this reason. Actually price often has very little to do with quality. The books on this list are books that children will enjoy and profit by. It is hoped that parents who find that a certain book or author arouses great interest will explore further and find other books that will open wider the doors of their children's minds.

This list makes no pretense of doing more than putting down the names of a few good books of each kind, grouped into classes with reference to children's interests and to their varying levels of development. Many others are equally delightful, but lack of space makes it impossible to list them.

EXPLORING THE WORLD OF JOBS. By Donald E. Kitch. Science Research Associates, 57 West Grand Avenue, Chicago 10, Ill. 1952. 40 pp. 40 cents.

To help young people to look at jobs realistically and intelligently is the purpose of this booklet. It surveys the jobs held by members of families of students in a hypothetical class and points out the social contributions made by all the workers and the requirements and rewards of various jobs.

A teacher or other worker using the approach of this booklet with boys and girls 13 to 14 years of age should be able to forestall to some degree the unrealistic attitude toward vocations that often characterizes youngsters.

Elizabeth S. Johnson
U. S. Department of Labor

Illustrations:

Cover, Public Housing Administration.

P. 19, George Washington University.

P. 20, George Jones.

P. 21, *Baby Talk*.

Pp. 22-24, Esther Buley.

Pp. 26 and 27, *Public Aid in Illinois*. Illinois Public Aid Commission.

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Published 10 times a year by the
Division of Reports, Children's Bureau

Editor, Sarah L. Doran
Art Editor, Philip Bonn

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CHILDREN'S BUREAU
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Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children.

The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau.

THE CHILD is sent free, on request, to libraries and to workers in fields concerning children; address requests to the Children's Bureau, U. S. Department of Health, Education, and Welfare, Washington 25, D. C.

For others the subscription price is \$1.25 a year. On all orders of 100 or more sent to one address there is a discount of 25 percent. Single copies 15 cents each. Send your remittance to the Superintendent of Documents.

Government Printing Office, Washington 25, D. C.

Foreign postage—25 cents additional—must be paid on all subscriptions to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

THE CHILD is indexed in the *Education Index*, the *Quarterly Cumulative Index Medicus*, and *Psychological Abstracts*.

THE CHILD

NOVEMBER 1953



TO KEEP UP HOME-BOUND CHILDREN'S MORALE



MARGERY D. McMULLIN

BEFORE my 8-year-old son died, 16 years ago, he was confined to bed for many months. At that time I became sharply aware of the boredom and loneliness that a bed-ridden child faces.

Such a child cannot go outdoors to play actively, and thus loses many opportunities arising from the adventuresome spirit of growing children. And he is usually deprived of the mental and emotional stimulation that other children can give him.

I learned also how much can be done by adults in providing a home-bound child with opportunities for activities suitable to his condition.

After my son's death I determined to try to help other physically disabled children to live happier lives. But—just *how* to help them was the question. I knew that some devastating diseases restrict a child's activities for months, or years, or even permanently, but I knew little about them. I knew there must be many children with these diseases in my city, New York, but I didn't know how to reach them.

The doctor who had cared for my son suggested that I work as a volun-

teer in a hospital to learn more about these children. This I did for the next 2 years, in the pediatric clinic at New York Hospital. During that time, I had the opportunity of talking about the recreational needs of home-bound children with professional workers—doctors, nurses, medical social workers, and so forth. I also talked with mothers of children with long-term or chronic diseases; and all were anxious to get some help for their ill child.

The New York City Board of Education was providing for the children's formal education, but this did not cover their recreational needs. Many of the mothers, though they wanted to spend time with the sick child, were too busy doing housework and caring for other members of the family to pay attention to the child's need for diversion. Often a mother was too bewildered by the physical aspects of the child's illness.

My friends and I began to feel that an answer to these children's needs could be provided. We talked about a plan to provide volunteers who would go into the homes of children chronically ill and work toward building up their morale by helping them to engage in recreational activities.

The professional workers with whom we discussed the plan were in-

terested in providing recreational activities for their patients, though many of them had grave doubts as to whether this type of program could be successfully carried out by untrained people. Could a volunteer recognize his place in the professional picture? Could a volunteer be sympathetic and friendly without becoming too emotionally involved with the child and his family? Could a volunteer keep within the bounds of the work and refrain from giving advice that should come from hospital personnel?

Many questions arose

We all wondered how a volunteer would be accepted by the family. Would the parents resent the visits? Would they feel that an outsider was intruding? Would they feel that the visitor was checking up on their home life and activities? Would the parents understand and be helped by such a service?

And could a person without specialized handicraft training or skills con-

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tribute enough to the child's well-being to warrant such a program?

By June 1939 we had decided to test the idea. Beginning with home visits to six children with cardiac conditions, referred to us by the social-service division of New York Hospital, several of us launched what is now the Handicapped Children's Home Service, a voluntary, nonprofit agency. (We then called it "Diversional Home Service for Convalescent Children.")

The first group of volunteer visitors was made up of my friends and of students from Teachers College, Columbia University. During the first months, a small room in my home served as an office, and a nearby private school generously gave storage space for recreation equipment. Funds for office supplies, telephone service, and handicraft materials were given by friends.

News of the work spread rapidly by word of mouth to other hospitals, and more children were added to our list. Soon we needed additional volunteers, and we found them readily among students from various colleges, housewives, and men and women in business and professional life.

As the Service grew, so did the need for more money to carry on and expand it.

By 1941, the value of a volunteer program had been established, and many lay and professional people were keenly interested in the development of the Service. A group of 31 persons, including doctors, medical social workers, educators, and busi-

ness people, formed an association to carry out the program, with a board of directors to govern it.

Today, after more than 6,000 visits to over 300 children in 14 years, the purpose, function, organization, and structure of the Service are fundamentally the same as at the beginning. In 1945 the Service was incorporated, and the original ungainly name was changed to the present one. The board is now larger, more active, and more diversified.

Professional guidance needed

The names of children who need home visits are still referred to us by social-service departments of the hospitals, where the children are clinic patients who are on a regimen of complete bed rest or of restricted activity. But 13 more hospitals have been added to the one that referred children to us at the start. The policy of hospital referrals is followed, not only in order to reach the children who most need home visits, but also to enable us to receive the supervision and guidance of hospital personnel—indispensable in a program using untrained volunteer workers.

The Service tries to give each child stimulating occupations adapted to his age, his physical condition, and his interests. Each visitor is assigned to a specific child, and visits him once a week, bringing handicraft materials, books, toys, games, and the like. A visitor may bring something new each time, or he may bring a series of materials relating to a specific field in which the child is developing interest.

The visitor helps him to become familiar with the material, works with him as he learns to use it, and encourages his progress.

Nearly every child who is visited carries on some sort of handicraft, but other activities also are undertaken. If a child shows a keen interest in a hobby, the visitor will try to help him expand this interest. Music or art lessons are often given. With the consent of the hospital and the family, children who are up and about and those in wheelchairs may be taken out—to a museum, a ball game, a park, or a movie, or for a walk.

The boys and girls visited are from 6 to 21 years of age. Visits are made without regard to race or religion.

Many of the children referred for help have various forms of heart disease. Others are cerebral-palsied, or suffer from muscular dystrophy. Still others have poliomyelitis, or nephritis, or tuberculosis, or other diseases.

Although the Service now has a paid staff of three, including a supervisor, a great deal of the clerical work and all the visiting is done by volunteers. The volunteer visitors are recruited through churches, schools, clubs, colleges, and so forth.

Handicapped Children's Home Service is one of three organizations that offer required field work for academic credits in a course in vocational rehabilitation at New York University. Some other colleges list the Service as one of the agencies where students may get practical experience, though they do not give credits for such work.

Volunteers are asked to perform three duties: To visit a child each week for at least an hour, to write a report of each visit on a form, and to attend biweekly meetings. At some meetings, a doctor or a medical social worker discusses a special professional aspect of the program. At others, instructions are given in simple handicrafts and the use of play materials. Again, a meeting may concentrate on discussion of individual children.

As a rule, our most effective volunteers are employed people and college students. Employed people usually ar-

With his visitor's help and encouragement, this boy is increasing his skill in clay modeling. What is more important, the boy has developed an interest in life that he formerly lacked.



range their visits for evenings or week ends; college students have visiting times that fit their schedules. The best ages for this work are from the early twenties to about 45. People below that age group usually have insufficient confidence in their own judgment and are still living too sheltered a life. Older people as a rule are not sufficiently flexible, and may be unable to adapt themselves to families whose life patterns are different from theirs. We have found, however, notable exceptions among both younger and older people.

Many volunteers find that their visits have values—real though intangible—in their own lives. As one visitor said, "I soon discovered that while I was giving something in these visits, I was receiving much more."

When new volunteers wish to join us we ask them to fill out an application form and we interview them at some length. In this way, we learn something of each one's educational background, interests, and skills, so that we can make suitable assignments.

Before assigning a volunteer to a specific child, we pass on to him the information the referring hospital has given us about the child's interests, his disability, his family, and his general home situation.

On the first visit to the home a staff member accompanies the volunteer. Some volunteers work with the same child for months or years, others for briefer periods. Students usually take part in the program only during one or two school terms.

After each visit the volunteer fills out a report form describing briefly what took place. He notes the length of the visit; the items of equipment taken and their cost; carfare and other expenses. We require at least a brief report on these essentials, but also we try to train the volunteer to include whatever information might be helpful to the medical social worker or the doctor in charge of the case.

We send a copy of each report to the hospital that referred the child to us; and the hospitals tell us that these reports often throw light on pertinent aspects of the child's condition and

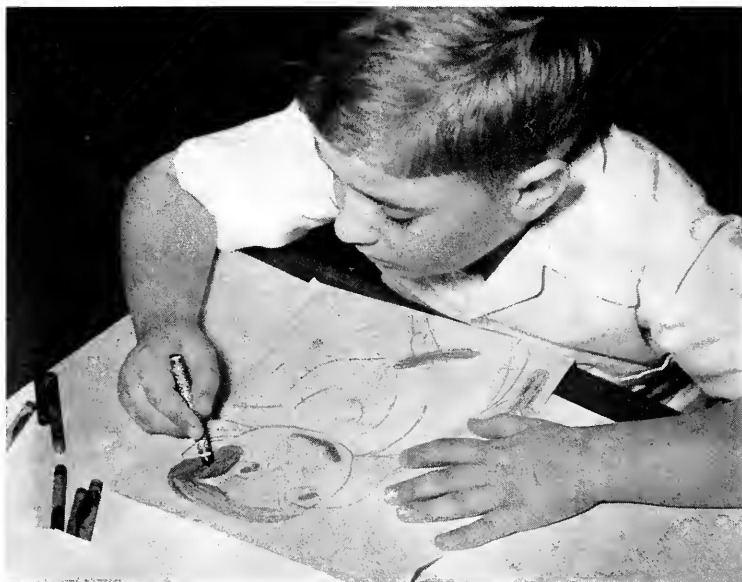
the family situation—information that the hospital is often unable to get because of lack of time for home visits by the medical social worker.

The children enjoy contributing to, and reading, a monthly mimeographed magazine called *The Children's Telescope*, which the Service issues. It contains pictures, stories, poems, letters, and articles by the children themselves, and news items about what they are doing. The children take turns as editor, with the

naturally out of the preceding one to the greatest extent possible.)

The method of work can best be shown through an example:

George had been hospitalized with rheumatic fever for a large part of his 16 years. He also had a spastic right hand. When referred to the Service, he was at home on complete bed rest. He was timid and shy, and had become quite neurotic and deeply depressed. His family took good care of his physical needs, but they were



Cartooning has become this handicapped boy's hobby since his visitor recognized his talent. The boy and the visitor discuss cartoon ideas, and the visitor brings drawing materials.

help of a specially assigned volunteer. They are encouraged to send in material for the publication, and topics are suggested for them to write about or illustrate. The magazine is an important morale builder; through it the children make friends, write letters to one another, and feel themselves part of a group.

How the Service works

In all the work, two principles are followed: 1. Attention shall be given to the special needs and circumstances of each particular child. (No stereotyped methods are employed.) 2. No activity shall be forced on a child. (Each activity is allowed to grow

overly anxious and solicitous, afraid to have him do anything. George spent his time worrying about his health and reading comics.

When referring the boy's name to the Service, the medical social worker described his home situation and his attitudes. The doctor felt that George should have a variety of quiet occupations. Both the medical social worker and the doctor assured the family that any activities developed by the visitor would not harm the boy.

The Service volunteer assigned to George had had wide training in handicrafts, and also a great gift of ingenuity. Finding out that the boy's

chief interest was in writing, she encouraged him to carry out an idea he had had for some time—the formation of a club for handicapped writers. She urged him to write to the editor of a writers' bulletin; the letter was published and George immediately received answers from shut-in writers from all over the country. His volunteer visitor helped him set up a filing system for the letters.

In connection with a newspaper that the club was planning, he learned to carry out a simple duplicating process. The speed with which all this happened was very stimulating to George. He was kept too busy with club activities to brood about his illness; and, through letters from a number of invalids much worse off than he was, began to realize that other people had problems also.

Early in the series of visits, George expressed interest in learning shorthand, but said that the orthodox systems were too difficult for him. Fortunately, his visitor was familiar with a kind of shorthand suited to the boy's abilities, and lessons began at once. The course occupied 6 weeks, and George practiced and studied every day between visits. By the end of that time, he had fully mastered the theory of the system and had put in a good deal of practice.

Meanwhile, the visitor considered the possibility of his learning book-binding as a handicraft. George first expressed interest in such an activity, but when it was demonstrated for him he was discouraged, and said he would not be able to learn it because it required precise manual skill. After studying the boy's physical difficulties, however, the visitor worked out several ingenious tools and gadgets to make the manual work easier. When the shorthand course was completed, she brought this special equipment and showed George how to use it. He was eager to try it out, and soon succeeded in rebinding a music book for a friend.

The effect on George was remarkable. In fact, the psychological results were as marked as the physical progress. When he found himself able to accomplish craft work that he

had considered beyond his capacity his self-confidence rose to a new high. In addition, the visitor was able to impress on him the idea that similar methods might be applied to many of his other difficulties, that the mechanics of doing things were simply an "engineering problem."

After a few months George's health improved enough so that he could attend school, and the Service visits ended. By this time his attitude and that of his parents toward his illness had changed greatly.

This boy's experience was, of course, unusual in that so much was accomplished in a short time. But it sums up the Service's methods and the way in which it tries to change the boredom and frustration of prolonged illness into constructive accomplishment.

When a new program is begun

Because we are often asked how a similar service can be started in another community, it is appropriate to pass on some suggestions that might help others initiate such a program.

1. Community interest. Essential to the success of such a program is the interest of the community, especially of three groups: (a) Professional people, (b) organizations whose members would be potential sources for volunteers, and (c) business and community leaders.

a. The professional people should include not only hospital personnel, but educators, public-health nurses, and workers in related fields.

b. The organizations—obviously indispensable—include church groups, social and business clubs, employee organizations, and colleges. Contacts with these should be constantly expanded, for their varying viewpoints bring a freshness of approach otherwise lacking.

c. The business and community leaders should bring most of the financial help, which is especially important if the service is to run as an independent agency. These men and women should also assume the responsibility for educating the public about the work, its significance, and its value to the community.

2. Children to be visited. The decision as to the children who are to have the opportunity for receiving service must be made in the individual community on the basis of the need and of the help available.

Some of the children will be referred by hospitals or social-service agencies; others by private physicians or the parents themselves.

The abilities of the volunteers will also affect the decision on what children can be accepted. Blind or mentally subnormal children, for example, would need visitors with special training or guidance.

And, of course, work with preschool children differs from that with 6- to 12-year-olds; and both differ from work with older boys and girls.

3. Size and type of the staff. The work of volunteers must be supervised by agency staff, and our experience indicates that, in such a highly individualized program, the absolute maximum of cases that can be properly supervised by one person is 50—and 40 would be a better figure. Besides the executive supervisor (or supervisors), the staff must include some full-time paid office help. Volunteer help can be useful in an office, but the keeping of accurate records should be the responsibility of a paid worker.

Medical social service is one of the essentials of a home-service program. If this service is not available through the referring agencies, a medical social worker should be available on a consultation basis or be included on the staff. An occupational therapist with special skills in working with volunteers would be a highly desirable addition as well.

4. Support of the program. There should be a clear idea of what financial help can be counted on. Salaries for the supervisor and office help must be paid, and expenses of the office, including supplies.

Some communities hold a once-a-year drive to raise funds for the support of all the agencies. But in most places fund raising is a necessary part of an organization's activities.

Support for the Handicapped Chil-

(Continued on page 46)

FOR MIGRANT FAMILIES

Ranch owners join with public and voluntary groups to provide community services

MRS. I. H. TEILMAN

COTTON has been grown in California's San Joaquin Valley for 30 years or more, but during the past decade production has skyrocketed so that cotton has become the State's leading crop. This has brought to the Valley counties, especially Fresno County, a great increase in the number of agricultural laborers and their families.

Until the boom, Fresno County's west side—now the site of enormous cotton ranches—was practically undeveloped. All the towns of any size, with their health and welfare facilities, had grown up on the east side. The county hospital, for example, is in the city of Fresno, 40 or 50 miles from any of the camps where the cotton workers live.

Hundreds of these camps, housing from 500 to 2,000 people each, are located on the great cotton ranches. The ranches, 3,000 to 68,000 acres in size, may employ 10,000 migrants at peak times, and many other workers who are permanent residents.

Some of the migratory workers also consider the county their home. Since cotton is the last crop of the year, many of the workers, who travel about in the spring and summer following various crops, not only stay in the camps on the cotton ranches through the usual picking season—from September to the end of January—but remain there until April, unemployed. Some stay on at that time to do cotton chopping, or thinning.

Conditions in some labor camps in various parts of the country have been

described again and again—crowded, dirty tents and cabins; babies malnourished and ill, lying exposed to flies and filth, or sketchily tended by an older child who should be in school; 3- and 4-year olds uncared for while their mothers work. This is part of the picture in many of these west-side cotton camps.

Lack of sanitation leads to a high incidence of infant diarrhea, and babies in the camps have died from this disease because they were so far away from medical care. The rate of death from infant diarrhea in the San Joaquin Valley counties has for many years been consistently higher than that for the State as a whole.

An emergency strikes

By late fall of 1949 the migrant situation had become desperate. The fall of that year was especially warm in the Valley, and the cotton matured early. To get the harvest in quickly, the growers took on an extra large number of laborers. The cotton was soon picked, and many thousands of the workers, instead of continuing to earn until the end of January, found

MRS. I. H. TEILMAN is vice chairman of the Rural Health and Education Committee, Inc., of Fresno County, Calif., a committee that represents every element of the community. The efforts of this group, described here, have brought opportunities for some community services to the families of migratory agricultural laborers in isolated camps.

Mrs. Teilman has written this article not merely with the idea of showing achievements, for she herself characterizes the results so far as only a drop in the bucket. Rather, her purpose is to point out how different groups in her community have been able to join hands and thus do much more than they could have done separately.

The author desires to give credit to the

themselves unemployed. A long cold winter followed, with resulting hunger and sickness. More babies than usual died. The workers felt that the community was indifferent to their hardships.

Long before this, some public-spirited citizens and official and voluntary agencies had been concerned about the health and welfare of the laborers' families. The Division of Home Missions, of the National Council of Churches of Christ, had for many years provided community workers to the camps, and other religious and lay groups had also worked to help the families. The Fresno County health department had always given the people in the labor camps as much health service as distance and funds would permit. And, some time before the emergency struck, the newly organized health division of the Fresno County Coordinating Council had begun to mobilize the forces of public opinion toward improving the health of the families in the labor camps. This group worked with the established official and voluntary agencies in their efforts to help the families.

But so far little had been done for the migrants by the community, and the unemployment throughout the Valley in the winter of 1949-50 called for immediate measures.

The Governor thereupon asked the State Department of Public Health to call together representatives of the various State and local agencies of the Valley, to put emergency measures into action.

A report on the causes of infant deaths in the Valley counties, made by the State Department of Public

many persons who are working on the project, especially to Mr. Tom O'Neill, Chairman of the Rural Health and Education Committee, Inc., and to Mrs. Hubert Wyckoff, Jr., Health Chairman for the Governor's Advisory Committee on Children and Youth.

Mrs. Teilman, a graduate of the University of California, has been health chairman for a number of organizations, among them California's State Federation of Women's Clubs and the Fresno League of Women Voters. She held the same office for the 1949 Fresno County Grand Jury and, from 1948 to 1950, for the Fresno County Coordinating Council. She is now President of the Coordinating Council and is a member of the California State Advisory Hospital Council.



At one of the modern health centers for which several Fresno County cotton growers have given the buildings, a mother makes an appointment for a health examination for her boy.

Health, focused attention on the agricultural laborers' families. It pointed to their unemployment, their remoteness from medical care, their poor nutrition, and the lack of sanitation in their homes.

The various Fresno County agencies concerned with the migrants' problems formed a closer tie by establishing an interagency committee, whose purpose was to dovetail the various efforts and accomplish more than the agencies had been able to do separately.

The Fresno County Department of Public Health, with the help and guidance of the State Department of Public Health, organized and conducted child-health conferences and immunization clinics in the labor camps. The State health department also lent the services of a health educator.

The county chapter of the Red Cross sent its workers into the camps to conduct classes in home nursing and in mother and baby care.

Home advisers on the staff of the county's Agricultural Extension Service visited the cabins and tents to teach the mothers how to use the surplus foods that were distributed by

the county Department of Public Welfare. (Migrants, not being residents of the State, could not be given relief money.)

The Fresno County General Hospital, which under ordinary circumstances does not admit nonresidents, temporarily waived this restriction and accepted children and pregnant women. (These are still admitted.)

Most of the services, of course, were provided only as temporary, emergency measures.

Stopgaps are not enough

In the spring of 1950, a commission set up by the Governor of the State held public hearings in different parts of the Valley and recommended ways of permanently meeting the workers' problems.

The State personnel and the interagency committee continued their work until March 1950, when spring employment became available to the migrant laborers.

The State Department of Public Health asked the Federal Government to help with a 6-month study of the causes of infant diarrhea, which was then so prevalent in the San Joaquin Valley counties.

Fresno County was chosen as the location of the study, which included stool examination for more than 7,000 children 10 years of age and younger. The Public Health Service (now of the Department of Health, Education, and Welfare) assigned to the study a doctor who is an authority on diarrheal diseases.

The county health department's public-health nurses explained the purposes of the study to the mothers of the children and helped to get the cooperation of the growers. The nurses began by getting in touch with a few of the women they already knew—women who were less shy than the others and were potential leaders. These in turn invited other women to join them in forming camp health committees. These camp committees—20 to 50 women each—"sold" the idea to other women; members went from door to door, carrying the story to the various families. In each of 26 camps a cabin was set up as a temporary clinic headquarters for the diarrhea study, and each family was given an appointment.

When a family brought the children to the cabin serving as a clinic, the samples of stools were taken and the children immunized against communicable diseases. The camp committee helped list family members needing medical attention—crippled children, pregnant women, malnourished mothers and children, and so forth. (Members of the camp health committees now act as volunteer helpers at well-child conferences and other clinics, which have since been established.)

The women on the camp committees were enthusiastic about continuing to work for better health for their families. But it was clear that the cabins that had been used for the immunizations and the diarrhea survey were not suitable places for giving health services. They were not large enough and not clean enough. Both the nurses and the mothers felt strongly that well-equipped places were needed, where the children could be brought for health services, and where the Red Cross classes in home nursing and mother and baby



The wife of a cotton-ranch owner helps out at one of the child-health conferences. The conferences are held in well-equipped buildings that have been given by several ranch owners.

care could be given in proper surroundings. They discussed this need with some of the growers, and also the need for a place where children could be cared for while the mothers worked.

Soon after the diarrhea survey was completed, in December 1950, a member of the Governor's Advisory Committee on Children and Youth proposed to a small group representing the county departments of health, education, and welfare, and the Coordinating Council, that a health and welfare project be planned for the families. This member suggested that a foundation be asked to provide funds to start the work, with the expectation that after the project was well under way local funds would support it. A small committee, later named the Rural Health and Education Committee, was formed to carry out the project.

It was agreed that of all of the many needs of the distressed families, which the work of the interagency committee had made clear, two of the most urgent were (1) health centers near where the families live, and (2) care of children while the mothers work. The Committee set out to help

fulfill these needs, and as many others as possible.

Complete information on the need for the project and the conditions under which it could be carried out was collected by the Rural Health and Education Committee and submitted to the Rosenberg Foundation. Late in 1951 the Foundation appropriated \$22,000 for the project.

All join hands

Since then the Committee has gradually expanded until it now includes about 60 members. Besides the official agencies for health, social welfare, education, and employment, the Committee now includes representation from such groups as the State Youth Authority, Fresno State College, the Red Cross, the Coordinating Council, the Fresno County Medical Society, the National Council of Churches, and the Agricultural Extension Service. Other members of the committee are clergymen, businessmen, wives of agricultural laborers, and growers. A grower serves as chairman of the committee—one of the many signs that the employers themselves are active in the community's efforts to help the migratory laborers' families.

Months before the Foundation funds were appropriated, the Fresno County Medical Society had agreed to help with the child-health conferences and with general medical and prenatal clinics. But before clinics could be established, a suitable place for holding them had to be found, and an appeal was made to the growers, through the county health department, to provide quarters for these services.

One of the growers, who is chairman of the Rural Health and Education Committee, had his permanent employees convert a barracks building on his ranch into a good building for a health center, and gave it for that purpose. These employees constructed cabinets, patients' examining tables, desks, a modern kitchen for use by classes taught by the Agricultural Extension Service, and a classroom for the Red Cross, as well as space for the clinics that were to be conducted by the health department. Other growers soon gave buildings, similarly equipped, and now six health centers are operating.

Curtains and other furnishings for the health centers were made by women of the camp health committees. Rosenberg Foundation funds helped to buy some of the instruments and other medical equipment, and the health department furnished medicines.

The clinics—general medical, prenatal, and well-baby—are staffed by resident doctors from the Fresno County General Hospital and doctors in private practice, most of whom live in Fresno. The county health department's public-health nurses work with the doctors and make follow-up calls. The adults' clinics are held in the evening, so that medical attention can be sought by the camp families without too much difficulty. The county welfare department helps to determine the families' eligibility for clinic service.

The first of the child-health conferences held at the new centers was opened in February 1951 and the first of the other clinics less than a year later.

In the beginning few patients came to the clinics, but as the news has circulated among the camps, attendance has increased greatly.

As an early step toward obtaining day care for children while their mothers work, it was necessary to let the west-side people see what centers for this kind of care are like. The Fresno public schools invited some of the growers, and the mothers on the camp health committees, as well as representatives of the west-side schools, to spend a day in the city's child-care centers. State Department of Education officials were invited to meet with members of the Rural Health and Education Committee.

Authorization by law needed

By the time these and other steps had been taken to help everyone concerned to become more familiar with the idea of child-care centers, public understanding had laid the foundation for starting a center. But at that time, although city school boards were authorized by law to establish child-care centers, rural ones were not. A bill was then pending to continue the child-care centers then existing in cities, but it did not authorize establishment of centers in agricultural areas. And without such a provision, no center could be opened on the west side.

The Coordinating Council wrote letters to all the legislators and also sent a representative to a hearing on the bill. Several of the west-side growers also went to the hearings and told of the urgent need for day care of children while their mothers were working in the cotton fields. These efforts were successful, and the new law when enacted made it possible for any of the west-side school boards to establish a child-care center when a ranch owner provided facilities for it. The law passed in June 1951, and the committee hoped that at least one center would open by the time the migratory workers arrived in September.

The school board obtained permission from the State Department of Education to establish a center, and levied a special tax to supplement the

State funds; the board also applied successfully to the Rosenberg Foundation for funds to help operate the center.

In August the same grower who had given the building for the first health center offered a machine-shop building on his ranch for a child-care center. In consultation with the child-care department of the Fresno Public Schools he had the building remodeled so as to be suitable for such a

take them home again at night. This year school busses are taking children to and from the center.

The center did not open till the end of October 1951, when the cotton-picking was well under way. Because of the late start and the newness of the project comparatively few children attended during the first season, but as a pilot project it was satisfactory. In the fall of 1952, with continued help from the Rosenberg Founda-



While the mothers are picking cotton, some of their children are cared for in California's first rural child-care center. School busses now take children to and from child-care center.

center. A satisfactory and colorful building resulted, with junior-size toilets, low washbasins, a large playroom, a sleeping room, a large sunny kitchen, and so forth. Facilities for child-health conferences are in an adjoining building.

Assistants given training

The staff, except for the well-trained head teacher, consists of local women; these were given in-service training, including the Red Cross course in home nursing. The fee paid by the parents is 6 cents an hour for each child; when two or more children are in the same family, the charge per child is lower. Only children who are over 2 years of age are admitted. Some of the parents drive 10 to 12 miles to bring their children to the center, and of course

tion, the center reopened, and more children attended.

In the present cotton-picking season, the child-care center is again operating; also the child-health conferences, the prenatal clinics, and the clinics for general medical care. All are well attended.

Meanwhile, other aspects of the health and welfare project have continued.

The Agricultural Extension Service, which received part of the Foundation funds, now has one full-time home adviser working in the labor camps on the west side. Trying to help the families to live better on low incomes, she explains about the foods that are essential to health, and teaches the mothers to make clothing, and to mend and remodel it; also to use such materials as feed sacks. She

gives instructions in rug-making from scraps and burlap sacks; storing food and clothing in orange boxes and other crates; and making housefurnishings from whatever materials are available.

Step-by-step advances

The work of the home adviser is particularly difficult. Many of the women in the migrant families feel that they already know how to cook well enough; others are shy and afraid they may be criticized. In the early stages of this work, most of the home adviser's time was spent in home visits. Now she has more time to hold classes (in the new child-care center), and some of the women are attending them.

The Fresno County Chapter of the American Red Cross has participated in the project in spite of a reduced budget and without any Foundation funds. Its workers have continued the classes in home nursing and mother and baby care that were begun during the emergency period.

The National Council of Churches is continuing its long-time work for the migrant families in this area. This project, called the Fresno Area Migrant Ministry, is separate from that of the Rural Health and Education Committee, although its director is a member of the Committee. The Council finances its own project, with the help of the Fresno Community Chest. Besides general welfare work and religious education, the project includes many recreational activities; it also offers parent education.

All this may sound like a success story in that many of the families now are getting some help. In fact, we of the Rural Health and Education Committee feel that the project has been fairly successful.

Gains become clear

For example, we are told by the health department that the incidence of communicable diseases has been cut. Not a single case of diphtheria has been reported in the county since January 1, 1952, and much less diarrhea has occurred among the children whose mothers have been bringing

them to the child-health conferences. The administrator of the county hospital points to a decrease in the need for hospitalization among the children of the west side. Again—and this is most notable—our county director of public welfare tells us that public funds for "indigent burial" of infants of west-side families are no longer needed.

The field director of the American Medical Association's Council on Rural Health, who had visited the west side before the project was started, visited it again later, and told us that he was gratified that the children have benefited so much.

Just as important as the improvement in health among these families is the fact that they now have a feeling of group participation and community responsibility.

The work of the Committee has been far from easy. Surveying the needs and planning the services were comparatively simple steps, but getting the families to join in the project has been another story.

Here we have families who live in a group, yet in the past have known nothing about getting together for the common good. Because of poor economic conditions and lack of opportunity in the places they came from, these people have become exceedingly fearful. Never having had any health or welfare services, many are reluctant to use them. It has taken special skill on the part of the nurses and other workers to gain the families' confidence.

The Rosenberg Foundation has continued to grant funds to the Committee, but these funds will not be available after November 1, 1953. After that time, the county government will take over the project; the growers, who have already contributed so generously, have agreed to underwrite half the cost.

We know that we have not yet been able to meet some of the problems, such as the need for better housing, with plumbing; and the need for fly control, lack of which adds to the spread of diarrhea.

Now that we have some facilities for taking care of children over 2

while their mothers work, we should like to do something about similar care for children under 2 years of age; for the need is very great. But special nurseries will be needed, and we have a long way to go before that goal can be attained.

Separately from the efforts of the Committee, the county is working to fulfill another aspect of the migrants' problems—the needs of the school children. Fresno County's Superintendent of Schools has recently announced that a \$10,000 grant has been received from the Rosenberg Foundation to finance a study of these school children. The study, which will be directed by a general consultant of the elementary schools of the county, will be centered in 16 west-side schools.

The project is expected also to enable the schools to help the migrant children not only with their studies, but also with problems in health, citizenship, home life, and future vocations.

What of the future?

In recent years more and more cotton-picking has been mechanized. Last year nearly two-thirds of the west side's crop was picked by machine, and this year the estimate is three-fourths. As this trend continues, less help will be needed, but some of the present laborers will be taught the skills necessary for machine work and will then hold stable jobs instead of having to follow the crops from place to place. It is hoped that in the long run the families of these workers will have a better lot than they have had in the past.

The Committee realizes that its work so far is only the proverbial drop in the bucket, even in our own county. Our hope is that this story will suggest that much more can be done, not only in this county, but in other areas with similar problems. And much *can* be done when all agencies and individuals concerned with the problems of the agricultural laborers work hand in hand to give these neglected people and their children a chance for better health and a happier life.

CAN COST ACCOUNTING HELP SOCIAL AGENCIES?

JOHN G. HILL

FEW SOCIAL AGENCIES know either the aggregate or the unit costs of the services they are rendering. They know their total annual expenditures, of course, but few agencies render a single type of service, and the amount that each type is costing is usually unknown. A children's agency, for example, may supervise children in their own homes, place them in foster homes, and place them for adoption, and it may also operate an institution. The combined yearly cost of these operations will be a matter of record, but the cost of each, as a rule, will not.

Analyzing these costs is a complicated procedure because the nature of a social agency's work rarely permits the various services it offers to be sharply departmentalized. For instance, usually the same staff workers engage in foster care and in adoption work and provide casework service to children in their own homes and in institutions.

Just where do the funds go?

What is of greatest importance, many agencies do not know how much of the money they are spending is going into services directly beneficial to the children or other clients and how much is going into what might loosely be called overhead expenses, such as case recording, staff supervision, staff and committee meetings, conferences, professional staff development, public relations, and similar activities. In the absence of any genuine controls some of these activities may develop an insidious habit of growing out of proportion to their in-

tended purposes. Periodically computing the cost of these activities would provide the means and incentive for bringing them into line with the primary purpose of a social agency, which is to serve people.

Thus, if an administrator were sure about the cost of the different services of his agency and of the various processes that go into performing them, he would be in a position to cut a better pattern from the cloth he has. More service to clients probably would result. And even when the administrator finds it necessary to retrench he could probably do it more wisely and selectively.

Cost accounting has another important advantage that applies particularly to the children's field. This is the matter of fees for service. Fee scales, when parents and other clients are able to pay for service, would probably be more realistic if the costs of service were known. In adoption, an itemized statement of the cost of the services involved might help in charging proportionately for these services. It is possible that use of such a statement may even open the way for charging adoption fees in

States where such fees are now prohibited.

When public funds are used to pay for the services of voluntary organizations — a practice common in the children's field—information on the actual cost of the services subsidized might lead to wiser allocations, and the public would have greater assurance about what it is getting for its money. In fact, purchase of care at cost would be more equitable than flat subsidies.

Similar agencies functioning in the same fields of social work could furnish cost-accounting data for comparisons among those agencies; and this would probably lead to formulation of new administrative and operational standards more specific than the ones agencies now have to guide them. In the children's field, for example, a range of the service and administrative costs for an adoption, or for a day's care, per child, in foster care or in a nursery would be a helpful yardstick that could be developed from data on costs of operating child-caring agencies.

A little more than a year ago, Family Service of Philadelphia, one of the 10 largest family agencies in the country, completed an analysis of its costs, made by applying cost-accounting techniques.

This experience with cost account-

(Continued on page 45)

A social agency is better able to fulfill its purpose when it knows how much of its money is used for service that directly benefits people and how much goes into overhead expense.



JOHN G. HILL is Research Director of the Health and Welfare Council, Inc. of Philadelphia. In his recently completed study of the Family Service of Philadelphia, cost-accounting principles and techniques were for the first time used in analyzing the costs of the services rendered by a casework agency.



TO MAKE THIS COUNTRY PROUD OF US

RICHARD BARNES KENNAN

“WE HOPE to make this country proud of us,” said Miriam Werth, 19 years old, one of a group of 50 foreign-born persons who had just become citizens of the United States. Miss Werth, a “displaced person,” born in Austria, spoke these words at the opening session of the Eighth National Conference on Citizenship, which met at Washington September 17-19 under the auspices of the U. S. Department of Justice and the National Education Association.

For that session, which took place on the 166th anniversary of the signing of the Constitution of the United States, the presiding judge of the U. S. District Court of the District of

Columbia, the Hon. Luther W. Youngdahl, had designated the scene of the Conference as a courtroom for the purpose of admitting new citizens. Judge Youngdahl administered the oaths of allegiance.

September 17 is Citizenship Day

This is the second year that a court has granted naturalization in connection with the Citizenship Conference. Both last year and this year the naturalization took place on September 17, the date that Congress in 1952 designated as Citizenship Day.

The 50 new citizens were welcomed

RICHARD BARNES KENNAN is Secretary of the Commission for the Defense of Democracy through Education, National Education Association, and Consultant to the NEA Citizenship Committee.

by a native-born American, Nancy Watkins, who reached voting age this year. Miss Watkins said, “In all its history, America has opened its doors to people from other lands. The vitality they have brought to this country, in exchange for the unique liberties and opportunities it has given them, has shown this to be one of the most successful experiments in history.”

Each year since 1946 the Conference has brought together representatives of organizations in every part of the United States that are interested in the rights and responsibilities of citizenship. This year about 800 organizations—civic, youth, religious, veterans’, educational, and other—were represented by about 1,000 persons, many of them teenagers. They came from every State in the Union and from each of the Territories and the District of Columbia.

At each of the National Conferences on Citizenship every delegate, regardless of age, race, creed, or any other factor, has participated in a discussion group. Even those who could not speak for themselves, on account of physical disability, have taken part in the discussion groups through interpreters.

On the second day of the Conference, “Youth Evening” brought boy and girl speakers to the fore. The youngest one was Adelaide Nacamu, of Peekskill, N. Y., who was born in Italy and whose father was born in Germany. Miss Nacamu told the Conference:

“Three years ago I became a citizen of the United States under my own name. (I had actually become a citizen prior to that time, but that was under my father’s name, for I was a minor.)

“I can remember the thrill when the officer called out my name, and I can still feel the lump rising in my throat when I answered to it.

“As I placed my hand over my heart and pledged allegiance to the flag the words took on a new significance. I had said those words over and over again in school, but that day they meant something new. Now when I say, ‘I pledge allegiance to the flag of

the United States of America and to the Republic for which it stands,' I feel as if these lines were written for me—and they were!! They were written for me and for every other American citizen.

"After I again raised my hand and swore to support the Constitution and obey the laws of the land, it was over. I had all the rights and responsibilities of a citizen.

"Some people have a wrong idea about democracy. They think that democracy is supposed to give us certain rights—for free. But this is not true. Every right involves a responsibility. Anyone who claims his rights without also fulfilling his responsibilities is taking something that does not belong to him.

"I am, as is every American, proud and happy to be able to be of some service to the United States, because the reward is tremendous. Yet, I try never to belittle other countries, since they are important to the success and happiness of our own.

"Since that day 3 years ago when I became a citizen, I have been and still am proud to say that I am an American."

The keynote address was made by the Hon. John J. Parker, Judge, United States Circuit Court of Appeals, Fourth Judicial District. To the question "What price freedom?" (this question was the theme of the Citizenship Conference) Judge Parker answered: "Work, vigilance, endless effort, self-denial, sacrifice . . ."

Among others who addressed the

Conference were the Hon. Herbert Brownell, Jr., Attorney General of the United States; Dr. William A. Early, President of the National Education Association; and the Hon. Argyle R. Mackey, Commissioner of Immigration and Naturalization, Department of Justice.

The findings of the discussion groups were presented to the final session of the Conference by Dr. William S. Vincent, Executive Officer of the Citizenship Education Project of Columbia University.

What is freedom?

Dr. Vincent left no possibility for complacency on the part of those who participated in the Conference. He pointed out that there had been a wide variety of opinions among the conference delegates concerning the exact nature of freedom. And he warned, "Ignorance of what freedom is, on the part of our own people, is a *very dangerous thing*. You can lose freedom if you don't know it when you see it—if you pursue a thing you think is freedom when it isn't freedom at all."

Later Dr. Vincent referred to another finding of the group discussions—that "the essence of freedom is this: those who are affected by decisions have some voice in the making of these decisions. This does not mean that everybody is going to get his way. But everybody has the right to voice his way and to press for it. It is in this way that progress is made toward the ideal objective of our society."

COST ACCOUNTING

(Continued from page 43)

ing has demonstrated some of the potential advantages to other casework agencies, besides those in the family field.

The cost data gave the staff, the administrator, and the board of directors a clearer picture than they ever had before of how the agency funds and staff time were being spent.

The general result was a reappraisal and replanning of many phases of the agency's day-to-day activities. This was done with regard to scheduling meetings and conferences, using staff supervision, and carrying out procedures concerning case recording and case handling. Statistical compilations were simplified, and new standards were set for the daily average number of client interviews per worker.

During the first year after the study, the agency found it possible, without impairing the quality of service in the least, to provide more service to clients for approximately the same amount of money as it was spending 5 years ago, despite the marked increases in salaries and other costs during that period.

Because of the differences between business enterprises and welfare agencies, a number of adaptations in standard cost-accounting methods are necessary in applying them to social agencies. In response to numerous requests, the methods used in the study made by the Family Service of Philadelphia have been described in detail in a cost-study manual to be published by the Service very soon. This manual sets forth not only the detailed procedures used, but also the reasons for each step, in the hope that it will be of use to other casework agencies, both public and private, in which there is interest in attempting to apply cost accounting to their work. When the manual is off the press, copies may be purchased from Family Service of Philadelphia, 311 South Juniper St., Philadelphia 7.

Some group leaders at the Eighth National Conference on Citizenship take part in a demonstration group discussion. The leader shown fourth from left in the picture is a teen-ager.



HANDICAPPED

(Continued from page 37)

dren's Home Service comes from voluntary contributions, from nominal fees paid by the hospitals that refer children to us, from grants by a few funds and foundations, and from fund-raising benefits of various types. The Service makes no charge of any kind to the families of the children visited. Obtaining adequate financial support is not always easy for an organization doing work like this; for these are the children you seldom see, and it is sometimes hard to dramatize their need. An important reason for the financial problems the Service has experienced occasionally is that when it first began, no one realized that its value would result in so much expansion, and therefore it has grown faster than its financing. When these children's needs can be presented to the community effectively, the public responds generously.

Problems will be encountered wherever such a service is established. No matter how many children need the help, and no matter how many people are interested in volunteering, it is not always possible to keep the number of children and the number of visitors balanced—especially as visitors can by no means be assigned indiscriminately, for child and visitor must be suited to each other as much as possible.

Another serious question is what to do when a boy or girl who has been visited for several years reaches the limiting age level of 21, if no program of aid to handicapped adults is available. For even cities with good rehabilitation and employment programs for the handicapped who are up and about seldom have suitable programs for the bedridden.

The experience of the Handicapped Children's Home Service indicates clearly that the benefits of such a program are not confined to the children themselves. Home visits give great help and encouragement to the other members of the child's family. Also, this work is of direct, practical usefulness to hospital personnel. Again, it offers valuable training and experience to student visitors, and to non-

students an opportunity to make a worthwhile contribution to the well-being of children whose lives are severely restricted. And, through the visitors, staff, and supporting agencies, it helps make the community increasingly conscious of the needs and problems of the home-bound handicapped child.

IN THE NEWS

Child-welfare personnel. On June 30, 1952, nearly 4,900 persons were reported as being employed full time in professional positions in the child-welfare programs of State and local public welfare agencies. This number, the largest ever reported, exceeded the number employed on June 30, 1951, by 5 percent. Over 1,400 clerical personnel working full time in the public child-welfare program were aiding this professional staff.

Services to children were also provided by State and local public welfare agencies through about 3,400 general welfare workers, primarily public-assistance workers. This latter group, however, served a relatively small proportion of children—less than a fifth of all the children receiving public child-welfare services.

The reports came from all the States, the Territories, and the District of Columbia. Data for California, Kentucky, Maryland, and Pennsylvania were incomplete. It is estimated that if all the States had reported completely, there would have been, at the time the reports were made, an additional 200 public child-welfare employees in professional positions throughout the country.

Orphans. Public Law 203, the Refugee Relief Act of 1953, approved August 7, 1953, includes a provision for issuance of not more than 4,000 special nonquota immigrant visas to eligible orphans under 10 years of age by December 31, 1956. The total program, including that concerning the orphans, will be carried out by the Administrator, Bureau of Security and Consular Affairs, Department of State, Washington 25, D. C.

Another law, Public Law 162, approved July 29, 1953, provides for entry into the United States of not more than 500 orphans under 10 years of age, who have been adopted abroad or are to be adopted in the United States, by United States citizens serving abroad in the United States

Armed Forces or employed abroad by the U. S. Government. December 31, 1954, is the deadline for the issuance of special nonquota immigrant visas under this law.

Births. If 1953 continues to lead 1952 in the number of births, as it has done so far, a new all-time high will be established. During the first 7 months of this year the estimated total births, adjusted for underregistration, was 2.5 percent higher than last year's figure, according to the National Office of Vital Statistics, Public Health Service, Department of Health, Education, and Welfare.

Since the end of World War II, more babies have been born every year than in any wartime or prewar year. From 2,858,000 registered and unregistered live births estimated for 1945, the total soared to 3,817,000 in 1947. After dropping to a slightly lower level for the next 3 years, birth totals reached a new high in 1951, broke the record again in 1952, and probably will top 1952's figures in the present year.

Accidents. The death rate from accidents among boys and girls aged 1-19 was cut only 16 percent during the period 1940-49; the reduction in the rate for all other causes of death in that age group was 46 percent.

Cerebral Palsy. Concerning the article published in the August-September *Child*, "Cerebral-Palsied Children Attend Special Classes in Public Schools," by Helen M. Wallace, M.D., Leona Baumgartner, M.D., and William Cooper, M.D., Dr. Wallace writes: "We failed to mention that in 1952, and again in 1953, United Cerebral Palsy of New York, Inc., has given the program about \$60,000. Without these generous contributions, and the organization's interest and cooperation, the city's Department of Health and Board of Education would not be able to give cerebral-palsied children as much service, or as high-quality service, as these children are now receiving."

Omission. In the October issue of *The Child*, we published an article by Mrs. George W. Gibson, "A Mother Speaks," which was given at the Fifth American Congress on Obstetrics and Gynecology. But we accidentally omitted to say that this article is one of a series of four papers on the doctor-nurse-patient relationship in maternity care, which appeared as part of the Transactions of that Congress, edited by George W. Kosmak, M.D. We regret this omission.

• FOR YOUR BOOKSHELF

WE ADOPTED THREE. By Ernest Cady. William Sloane Associates, New York. 1952. 250 pp. \$3.50.

Besides three adopted daughters, this couple has a son, who was born to them 9 years before the first adopted daughter joined the family. This baby girl was obtained through a child-placing agency, the second through a physician, and the third through a domestic-relations court.

The book gives an account of happy family life, with reassuring discussion of the fact that the things that happened might have been just as varied and unexpected even if all the children were born to the parents.

Although at times the author seems to overemphasize the fact of adoption, this attitude probably was not so evident in the actual life of the family. In any event the intelligent and unusually sympathetic understanding shown by the parents would undoubtedly tend to minimize this.

An adoption worker might well suggest this book to a family about to adopt a child, or to one that needs reassurance about the normality of a child's unexpected behavior.

L. Evelyn Smith

THE CHILD WITH EPILEPSY (CB Folder No. 35). 15 pp. **THE CHILD WHO IS HARD OF HEARING** (CB Folder No. 36). 14 pp. Federal Security Agency, Social Security Administration, Children's Bureau. Washington. 1952. For sale at 5 cents each by the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Single copies available from the Children's Bureau without charge.

Workers in programs for handicapped children often need simply worded material that they can recommend to fathers and mothers of such children. Such information is given in folders issued by the Children's Bureau.

"The Child With Epilepsy" describes this condition, estimates how many children have epilepsy, and outlines the kind of care such children need. It points out that children with epilepsy can go to a regular school if their seizures are largely controlled, and tries to dispel some of the myths surrounding the disease.

"Most hearing loss in children is the result of repeated colds and infections in the ears, nose, and throat,"

says "The Child Who Is Hard of Hearing," and it adds that quick attention to any infection of this kind will prevent most hearing loss. The pamphlet offers hints to parents on how to help their child if he does not hear well.

CHILDREN WITH IMPAIRED HEARING; an audiologic perspective. By William G. Hardy. Federal Security Agency, Social Security Administration, Children's Bureau. CB Pub. No. 326. Washington. 1952. For sale at 5 cents each by the Superintendent of Documents, Government Printing Office, Washington 25, D. C. Single copies available from the Children's Bureau without charge.

Much has happened in the past 10 or 15 years to motivate changes in an approach to the problems of children with impaired hearing, says Dr. Hardy.

The result has been the emergence of a new branch of science called audiology. Audiology is a highly derivative, eclectic field of knowledge. It represents a synthesis of several fields—among them otology, physics, psychology, linguistics, biophysics, psychoacoustics, and pedagogy—undertaken for a specific purpose: to study and to treat the problems that relate directly to hearing and hearing disorders. The bibliography of research and clinical findings on these problems has multiplied a hundred-fold in the past decade.

With this surge of interest there has come a new perspective, focused on both philosophy and methodology, and with the emphasis on prevention. This perspective involves a combination of medical and nonmedical methods and techniques and attitudes wherein the problems of impaired hearing are not the work of a narrow field of specialization, but of the special interests of seven or eight fields of knowledge which find a common ground in appraising and meeting the needs of the person with impaired hearing. This is the audiologic perspective.

Dr. Hardy lists seven steps in an approach to the problem of impaired hearing in children. (Only the first four or five, he says, are pertinent for most children with hearing impairment.) The steps are: Public education, regarding both hearing and hearing impairment; adequate case-finding; thorough diagnostic examination; medical and surgical treatment as indicated; audiologic study and consultation; appropriate special education; and vocational rehabilitation and training.

GUIDE FOR STUDY GROUP LEADERS. Family Life Education Program of the Toledo Public Schools, Board of Education Annex, 1916 1/2 Vermont Avenue, Toledo 2, Ohio. 1953. Processed. 42 pp. \$1 postpaid.

The program for which this Guide has been prepared used workshops as a method of training lay people for leadership in parent education. Though the bulletin places more emphasis on philosophy than on techniques, it describes many practical aids to communication.

The bulletin includes a form for indicating a participating observer's impressions of what takes place at a meeting; such a form can serve as a useful basis for discussions.

•
"Does a 5-year-old child have any cash value? What, if anything, is it worth to restore a crippled person, who is a care upon his family or a burden on his community, to a position where he may become self-supporting and self-respecting once more? What is the cash value of a healthy mother, as compared with a sickly mother? . . . Are the lives of our children and the health of our mothers worth anything at all? . . . I think our children are worth much more than all the millions of Detroit and Chicago put together."

—George D. Aiken

• CALENDAR

- Dec. 2-5.** American Public Welfare Association. Biennial Round Table conference. Chicago, Ill.
- Dec. 10.** Human Rights Day. 5th anniversary of the Universal Declaration of Human Rights.
- Dec. 26-31.** American Association for the Advancement of Science. 120th annual meeting. Boston, Mass.
- Dec. 27-30.** American Statistical Association. 113th annual meeting. Washington, D. C.
- Dec. 28-30.** American Anthropological Association. 52d annual meeting. Tucson, Ariz.
- Dec. 28-30.** American Economic Association. 66th annual meeting. Washington, D. C.

Illustrations:

Cover, Esther Bubley.
Pp. 34-36, courtesy of the author.
Pp. 39 and 40, courtesy of the Fresno Bee.
P. 41, courtesy of the Westside School District, Fresno County, Calif.
Pp. 44 and 45, courtesy of the National Citizenship Committee.

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Published 10 times a year by the
Division of Reports, Children's Bureau

Editor, Sarah L. Doran

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Publication of THE CHILD, monthly bulletin, has been authorized by the Bureau of the Budget, September 19, 1950, to meet the needs of agencies working with or for children.

The Children's Bureau does not necessarily assume responsibility for statements or opinions of contributors not connected with the Bureau.

THE CHILD is sent free, on request, to libraries and to workers in fields concerning children; address requests to the Children's Bureau, U. S. Department of Health, Education, and Welfare, Washington 25, D. C.

For others the subscription price is \$1.25 a year. On all orders of 100 or more sent to one address there is a discount of 25 percent. Single copies 15 cents each. Send your remittance to the Superintendent of Documents,

Government Printing Office, Washington 25, D. C.

Foreign postage—25 cents additional—must be paid on all subscriptions to countries in the Eastern Hemisphere and those sent to Argentina and Brazil. Domestic postage applies to all other subscriptions.

THE CHILD is indexed in the *Education Index*, the *Quarterly Cumulative Index Medicus*, and *Psychological Abstracts*.

THE CHILD

DECEMBER 1953



Each year the Children's Bureau brings together, in this publication, observations on what is happening to children in the U.S.A.; some highlights in services for children; some trouble spots in child life. This report covers the year ending June 30, 1953.

growing

growing

A RECORD

Births in 1952 set a new annual record, with 3,824,000 registered. This number topped the all-time postwar peak, in 1947, by 124,000. The birth rate in 1952—25 per 1,000 population—was near the highest point in 25 years.

MORE THAN EVER

With births up and deaths down, the child population in the United States was greater than ever before in history. In 1952 the Nation had 50 million children under 18 years of age. This was an increase of 25 percent over the 40 million in 1940.

The number of very young children has shown the most spectacular rise. There were 10½ million children under 5 years old in 1940; in 1952, there were 17 million—a gain of 63 percent. Already unprecedented claims are being made on the Nation's health and welfare services for preschool children.



Children from the postwar wave of births are now entering the school-age group. Those 5 through 9 years increased 40 percent, from 10½ million in 1940 to 15 million in 1952. Pressure for services for these children is mounting.

Most of the children aged 10

through 17 years in 1952 were born in depression years when birth rates were low. Their number went from 19 million in 1940 to 18 million in 1952, a drop of 4 percent.

MORE COMING

A child population even greater is predicted by 1960. By 1960, the United States is expected to have 61 million children under 18 years. The group under 5 years may drop a little because, owing to fewer births in depression years, fewer women are now entering the age of motherhood. The number of children aged 5 through 9, it is anticipated, will increase by nearly 4 million; and those 10 through 17 will go up by over 7 million. The Nation's services for teen-agers can look ahead to increasing demands.

FAMILIES INCREASE

The United States had 40 million families in 1952, 8 million more than in 1940. Most children live with both parents, but one or both parents were missing from the homes of 1 out of every 7 children. One out of every 11 children was living with one parent only; one out of every 17, with neither parent.

TOWARD BIGGER FAMILIES

A trend toward larger families has appeared since World War II. Birth certificates filed in 1951 reveal that 32 percent of infants born were first children; 29 percent, second born; 39 percent, third children or of a higher order of birth. Births of third children increased 9 percent over the pre-

vious year; births of fourth children increased 13 percent.



FEW "DO" FOR MANY

A relatively small number of families continue to carry the heaviest responsibility for raising the Nation's children. In 1951, over half the children under 18 years belonged to 16 percent of its families. These are the families with three or more children.

MARRIAGE AND DIVORCE DROP

Both marriages and divorces decreased from their 1946 peaks. An estimated 1.6 million marriages took place in 1951, a drop of 30 percent from 1946. The 381,000 divorces in 1951 were 38 percent under 1946.

BIGGER FAMILIES—LOWER INCOMES

The median (half are higher, half are lower) income of all families in the country was \$3,700 in 1951. As a whole, families with one, two, or three children in 1951 had incomes above the national average. In larger families, family incomes were well under this national average. Those with four children averaged \$3,580; with five, \$3,250; with six or more, \$2,725. More than one out of three children in the

GROWING

61 million in 1960

50 million in 1950

40 million in 1940

country lived in a family whose income was less than \$3,000. One in six was in a family with an income of less than \$2,000.

LIVING COSTS INCH UP

No drastic change took place during the year in the cost of living, but it continued its upward rise. In June 1953 the consumer price index was 114, compared with 113 a year before. (1947-49—100.)



MORE MOTHERS ARE EMPLOYED

In 1946, one out of every five mothers with children under 18 years of age had jobs outside the home. In 1952, it was almost one out of every four—over five million mothers. More than two million of these mothers had children less than 6 years of age.

Women whose husbands earn little are most likely to be in the labor force. In 1951, in families in which the husbands earned less than \$1,000 a year, 36 percent of the wives worked. Where husbands earned \$5,000 or more, only 17 percent of the wives were employed outside their homes.

CHILDREN IN INSTITUTIONS

The latest count (April 1950) shows that 205,000 children under 18 years of age were living in institutions. Fewer than half of these (93,000) were in institutions for dependent and neglected children. Another 31,000 were in training schools for delinquent children; 38,000 in homes and schools for the mentally retarded; 16,000 in homes and schools for the physically handicapped. The remainder, 29,000, were in mental hospitals, local jails and workhouses, or other institutions.

CHILDREN IN SUBSTITUTE HOMES

Some 170,000 children, in 1952, were in foster-family homes supervised by children's agencies. About 125,000 of these were in boarding homes to which an agency paid something toward their care; 32,000 were with families that planned to adopt them; and 13,000—usually older boys and girls—were in homes where they worked for their upkeep or received free care.

MORE BOYS AND GIRLS HAVE JOBS

Among boys and girls 14 through 17 years of age, one in four holds a job, full time or part time. In 1953, 21½ million boys and girls of these ages were employed—more than twice as many as in 1940. This increase is due to the fact that more and more high-school students are working at part-time jobs. Between 1940 and 1953 child-labor laws, the influence of public opinion, and improved school programs have cut in half the number of youngsters under 16 who leave school to enter employment.



SAFER THAN EVER

SAFER THAN EVER to be a mother

Maternal mortality in 1950 was the lowest ever. For 10,000 babies born alive, 8 mothers died. That represents a reduction of 78 percent since 1940.

While the record is good for the country as a whole, many States continue to have rates far above the national average. Rates in Alabama, Arkansas, Georgia, Mississippi, and South Carolina were about double the U.S. rate. In many isolated counties and small communities, rates are much higher than in metropolitan counties.

but . . .

The lives of some 1,300 mothers could be saved each year if all mothers in the United States had the care that mothers in most of our metropolitan counties have.

SAFER THAN EVER to be born

1950's infant mortality rate was the lowest in the Nation. Out of 1,000 babies born alive, 29 died. That represents a drop of 38 percent since 1940.

Much of the lag in reducing infant mortality is in the southeastern and southwestern parts of the U.S., and in counties and small communities isolated from medical and hospital resources.

but . . .

The lives of 10,000 infants could be saved each year if all babies in the United States had the care that babies in most of our metropolitan counties get.

MANY ARE BORN PREMATURELY

Each year about 280,000 babies are born prematurely in this country—more than 7 percent of all those live-born.

but . . .

The death rate for prematurely born babies is over 20 times that for full-term babies.

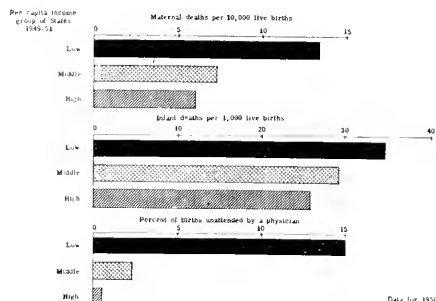
The spotlight now is on risks in the period before and during birth and in the first month of life. In 1950, a reported 39 out of 1,000 pregnancies that reached some 20 weeks or more of gestation resulted in death of the child before he was 1 month of age. Such deaths totaled 141,000, of which 73,000 occurred to live-born infants.

SAFER THAN EVER to live through childhood

The death rate from causes other than accidents, in the age group 1 to 19, was cut 46 percent between 1940 and 1949.

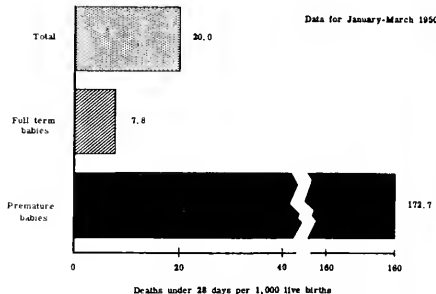
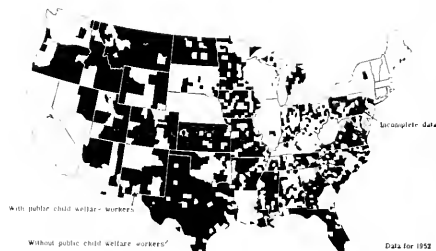
but . . .

During the same period the accident death rate in that age group was cut by only 16 percent. (Accidents are responsible for the deaths of over a third of the children who die—more than all the contagious diseases of childhood put together.)



LOW INCOME STATES HAVE THE HIGHEST MORTALITY RATES

HALF THE NATION'S COUNTIES HAVE THE SERVICES OF A FULL-TIME PUBLIC CHILD WELFARE WORKER



DEATH RATE FOR PREMATURE BABIES IS OVER 20 TIMES THAT FOR FULL TERM BABIES

RESEARCH MOVES AHEAD

CHILD health and welfare administrators and workers increasingly are showing an interest in evaluative studies: How effective, for example, are well-child clinics? What has been accomplished through delinquency-prevention programs? In what situations is foster care most likely to be helpful to a child?

Questions such as these are difficult to answer, both because they are broad and because they involve many knotty problems in scientific method.

Recognizing, however, that evaluation is a *sine qua non* of progressive and efficient administration, public agencies serving children are beginning to review and study their objectives, methods of work, and results. To help in this process the Children's Bureau made the principal focus of its research efforts in 1953 the review and development of methods of evaluating certain child-health and child-welfare programs and activities.

No comprehensive round-up of evaluative studies being made by State and city departments of health and welfare is possible here, but some examples serve to indicate the direction they are taking.

Practices evaluated

Philadelphia's Department of Public Welfare, suspecting that it could do a better job in placing children in foster care, undertook a study of its intake and placement practices. As a result, it has set up new procedures, and is testing them during a trial period.

Georgia's State Department of Health, for several years, has been conducting a school health project in three counties. The purpose of this project has been to develop and test procedures for a State-wide school health program. Under the project, every child entering the first grade is examined by a physician; if the child's family is unable to take care of the conditions for which the child needs

medical treatment, the project undertakes to attend to these. Teachers in other grades who spot children apparently in need of medical attention bring them to the attention of the project physician. Study and analysis are going on hand in hand with the operations of this project. An important part of the work is to find out the cost per child of various phases of the school health program. Results will be valuable in planning the extension of school health services throughout the State.

To improve social services

Wisconsin, which has specific legal responsibility for the welfare of children of unmarried mothers, is concerned with such questions as: What proportion of unmarried mothers receive social services? Under what circumstances do they fail to receive such services? What happens to children born out of wedlock? What happens to those placed for adoption? The State is laying the groundwork for research that will make services to these children more effective and is gathering data that will be useful in community planning.

How can a psychiatric facility best serve child-welfare workers? Here is a question being studied by Illinois' Department of Public Welfare. Several specially designated caseworkers on the staff of the Department's Institute of Juvenile Research are providing consultation to child-welfare units in two regional offices of the Department. Detailed records of the consultation process and of the subsequent casework are being kept to provide data for determining effective meth-

To help research workers throughout the country keep abreast of ongoing research projects directly related to children, the Children's Bureau maintains a Clearing-house, through which workers exchange information on such projects. In the 12-month period that ended December 31, 1952, some 1,100 current research studies were inventoried by the Bureau.

ods of carrying on this kind of work.

The need for evaluative studies such as these grows as programs grow in size and complexity. What must be continually considered is how well programs and measures supported by public funds achieve their purposes, and whether children, parents, and the public generally are well served by them.

With only a small research staff, the Children's Bureau is not in a position to undertake large-scale evaluative studies of its own, but it can do various things that will aid the evaluative research of others. It can arouse interest in this kind of studies, promote common planning, coordinate the efforts of widely scattered research workers, and give a certain amount of consultative service.

Bureau's work under way

With this focus for its research efforts, the Bureau worked in 1953 on:

A review and analysis of evaluative studies in health, welfare, and other fields, made with the aim of determining appropriate ways of conducting such investigations;

A pilot study to work out research methods for determining the influence of age at adoption on the subsequent adjustment of adopted children;

A study to compare several methods for determining a community's need for day-care services for children of employed mothers;

Review and analysis of studies evaluating the results of programs aimed at reducing delinquency;

Analysis of findings of a vision-testing study, conducted by the Children's Bureau with several other agencies, to determine the effectiveness of various methods of screening school children for defective vision.

In addition, the Bureau has been compiling information about the health and welfare of the children of migrant agricultural laborers, as a basis for further study of what is needed for these children.

A PARTNERSHIP COMES OF AGE

This year's record of public service for children has behind it 18 years of partnership that started on August 14, 1935. Then, through passage of the Social Security Act, the people of the United States directed their Federal Government to join hands with their State governments in extending and improving health and welfare services for children.

Under our Constitution, States bear the major governmental responsibility for the well-being of children. In making the Federal Government a partner in this great enterprise, the idea was not to shift the responsibility, but to strengthen the States' capacity to meet their children's needs. To this cooperative endeavor, both partners bring know-how and wherewithal.

The *know-how* that the Federal Government, through the Children's Bureau, brings is the experience and training of a small core of workers who are continually gathering facts and observations about what is happening to children; what help they need; what good jobs are being done; how second-quality jobs can be lifted to top-quality levels. This information is channeled out to the States to be used by them, as they wish, in extending and improving their work for children.

The *wherewithal* that the Federal Government brings to the partnership consists of annual grants of money. These carry certain requirements of law. But within these broad limits, the direction of their programs rests, as it rested before there was any such Federal-State cooperation, in the hands of the States. It is theirs to plan, theirs to manage—their own child-health and welfare services.

Federal contributions have grown over the years, but so have State expenditures. Maternal and child-health programs in 48 States, for instance, were financed in 1940 by a total budget of some \$11½ million. Over \$6 million came from State and local funds. For 1954, these States are budgeting \$40½ million; \$30 million will be from State and local funds. The same trend has taken place in State programs for crippled children. Today, with Federal funds for State child-welfare services some five times what they were in 1940, State and local funds meet four-fifths of the total public expenditures for such services.

Public services are only a part—sometimes a minor part—of the services for children. Voluntary services play a large role in building a healthy new generation. But even the utmost that both can do leaves many children beyond the reach of help from trained workers. Both public and private services have much to do before all our children have an equally good chance in life.

To help speed that day, Federal grants, under the law, take into account the size of child-care problems that States have in relation to their financial resources. These grants give due consideration to the special needs of

children in rural and other sparsely populated areas, where health problems are pressing and means to solve them are less accessible than in cities. Such grants help to equalize opportunities for children regardless of the part of the United States they live in.

Amounts that may be appropriated by Congress each year (under the 1950 amendments to the Social Security Act):

For maternal and child-health services (MCH)	\$16,500,000
For services for crippled children (CC)	15,000,000
For child-welfare services (CWS)	10,000,000

Amounts available to the States, up to the fiscal year 1955, are the totals appropriated each fiscal year plus carryover balances from 2 previous years in the Federal Treasury July 1.

Program	Fiscal year 1953		Total
	Appropriation	Carryover	
MCH	\$12,747,000	\$ 724,000	\$13,471,000
CC	11,482,000	763,000	12,245,000
CWS	4,371,000	3,793,000	8,164,000
Total	\$28,600,000	\$ 5,280,000	\$33,880,000

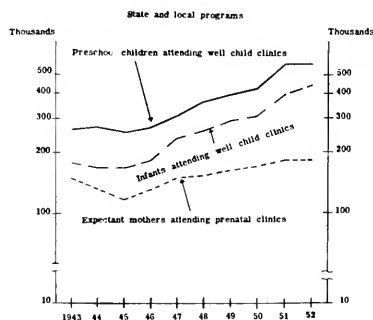
Program	Fiscal year 1951		Total
	Appropriation	Carryover	
MCH	\$11,928,000	\$ 140,000	\$12,068,000
CC	10,843,000	228,000	11,071,000
CWS	7,229,000	999,000	8,228,000
Total	\$30,000,000	\$ 1,367,000	\$31,367,000

Starting with the fiscal year 1955, balances in the Federal Treasury from previous years, by law, cannot be made available to the States. From then on each year's appropriation by Congress will be the total amount available for Federal grants to aid these State programs.

Children helped by State maternal and child-health services in the calendar year 1952

Examinations of school children by physicians reached an all-time high in 1952. There were 2,699,000 examina-

MORE MOTHERS AND CHILDREN ARE RECEIVING HEALTH SERVICES



tions, 5 percent more than in 1951, which had also been a record year. Slightly fewer school children—2,472,000—received inspections by dentists or dental hygienists. Nursing services to children of school age decreased a little, to a total of 2,533,000 field and office nursing visits.

There was little change in the number of infants and children of preschool age attending well-child clinics in 1952. Medical services were given to 1,014,000 at these clinics, compared with 982,000 in 1951. Nursing services were provided to 1,437,000 in 1952, and 1,430,000 in 1951.

Some decrease in maternity services showed up during the year. Some 181,000 expectant mothers attended prenatal clinics and 55,000 had postpartum medical examinations. These compare with 189,000 and 53,000 in 1951.

Immunizations given totaled 3,611,000 in 1952, 3,652,000 in 1951.

Children helped by State crippled children's services in the calendar year 1952

The year 1952 rolled up the largest number of children to receive physicians' services under these programs for any year since Federal grants were first made under the Social Security Act. The total was 238,000, compared with 229,000 in 1951. About two-fifths of these children are getting help the first time from these programs.

Some 191,000 of the children received clinic care; about 43,000 were cared for in hospitals, and 4,900 had convalescent-home care. Some 41,000 had home or office visits with physicians. Hospital and convalescent-home care accounted for the lion's share of expenditures under these State programs. About 1,360,000 days of hospital care and 473,000 days of convalescent-home care were provided.

In the early years of Federal aid to State crippled children's programs, the majority of children helped had conditions requiring orthopedic or plastic treatment. Today, care is gradually being extended to children with such conditions as rheumatic fever, congenital heart disease, hearing defects, cerebral palsy, and epilepsy.

Children helped by State child-welfare services at the close of 1952

At least 260,000 children were receiving child-welfare services from State and local departments of welfare on December 31, 1952. Forty-one percent of these children were living with parents or other relations; 42 percent were in foster-family homes; 17 percent were living

in children's institutions or elsewhere. (National estimates of the children served by public and voluntary welfare agencies showed a total of 400,000 on June 30, 1952. Public welfare agencies were reaching two out of every three of these children. Voluntary agencies are concentrated largely in urban areas and, for the most part, serve children of a particular faith, age, or race, or with some special type of problem.)

A wide variety of problems are handled by child-welfare workers.

Searching for, selecting, and supervising foster homes for children who cannot or should not stay with their own families is one of their jobs.

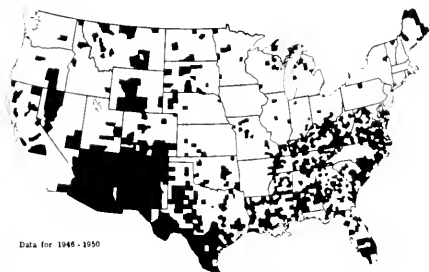
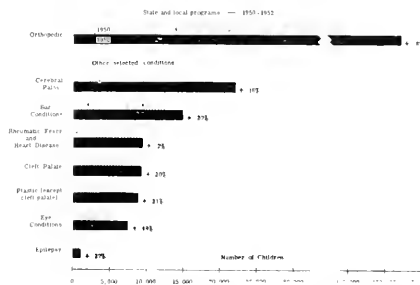
Finding the right homes for children needing a permanent home, and helping adoptive parents to find children, is another. (About 80,000 adoption petitions were filed in 1951, more than half of them by persons not related to the child. It is estimated that of the 38,000 children adopted by unrelated persons about half were placed in adoptive homes with the aid of a social agency.)

Helping unmarried mothers plan their own and their babies' future is another job of child-welfare workers.

When mothers go to a hospital or are ill at home, a trained homemaker, working under direction of a child-welfare agency, can do a lot to hold families together.

The right kind of institutional care must be found for some children; and plans for follow-up after the child returns to his home must be worked out. The licensing and inspection of group-care centers is an important job of some public child-welfare agencies.

"CHILDREN WITH ORTHOPEDIC CONDITIONS PREDOMINATE IN CRIPPLED CHILDREN'S PROGRAMS BUT CHILDREN WITH OTHER DIAGNOSES SHOW GREATER RATES OF INCREASE"



WHERE MORE INFANT LIVES COULD BE SAVED

Some employed mothers want their children cared for by experienced workers during factory or business hours. Developing and directing sound day-care plans for these children takes skill, and some child-welfare workers are looked to for help with such plans.

Increasingly, child-welfare workers see that an important part of their job is to get to families before trouble splits them apart and the children have to be cared for elsewhere.

Another important job they take a hand in is promoting community planning for children. In myriad ways, child-welfare workers help communities to work at removing the brakes on the good life for children in general.

1953 HIGHLIGHTS IN CHILD-WELFARE SERVICES

Increasing number of States developing services for mentally retarded children.

65 percent increase in number of full-time public child-welfare workers, 1946-52.

Public child-welfare workers continue active in State and community planning.

Small group-care units, close to communities, taking place of large, isolated orphanages.

9 States confer jointly on improving services for children of migrant families.

More state agencies provide special staff training on services for children in own homes.

States budget 10 percent of their Federal funds for staff development.

Cooperation increases between border communities in Texas and Mexico in planning children's services.

Social workers, like doctors, know how much better it is to get at sore spots before they have a chance to fester and so require drastic treatment. That is why they place emphasis on helping children in their own homes before troubles become so serious that substitute homes must be found for the children. **CHILDREN LIVING IN THEIR OWN HOMES**, newly published in 1953 by the Children's Bureau (Publication 339), identifies the kinds of children needing such social services, and the ways they can strengthen home life for children. Individual copies of this bulletin may be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D. C., for 20 cents.

Firmly rooted in the principle that States plan and administer their own services for children, child-welfare services throughout the Nation show great diversity and varying degrees of intensity. Only a few developments in 1953 can be highlighted here.

some problems facing child-welfare services

Providing foster care for children is the largest single cost item in the operations of public child-welfare services. As high living costs persist, more and more agencies are finding it necessary to reduce the number of children for whom they can provide foster care.

Although there has been a sizable increase in the number of trained caseworkers employed by public agencies in recent years, many States still report difficulty in getting enough such workers, especially at supervisory and consultant levels. More attention needs to be given to training personnel for work in the correctional field.

"Black market" placement of babies for adoption continues to disturb many communities, despite a small increase in supervised placements. Agencies are showing an increasing sensitiveness to the need for closer study of the "bottlenecks" in agency adoption services.

Agencies move toward early return of children from foster care to own homes.

At least a dozen areas report unused institutional facilities for dependent children, though at the same time there is a great unmet need for such facilities for mentally and emotionally handicapped children. An increasing number of such children continue to come to agency attention.

Cooperative planning by public and private agencies increases.

The need for additional day-care facilities for children of working mothers mounts as the number of employed mothers grows. Commercial centers tend to serve children from higher-income families. There is no noticeable increase in public services for other families.

While there have been hopeful developments in services to children in their own homes, there is large room for expansion.

Social services for delinquent children should—and in many States do—have close working relations with services for all children. The former are not highlighted in these pages, since special attention is given the problem of juvenile delinquency on page 60.

50 percent of all U. S. counties now have services of full-time public child-welfare workers.

Child-welfare agencies and social-work schools increase joint activities.

Gradual trend away from independent placement of children for adoption continues.

1953 HIGHLIGHTS IN CHILD-HEALTH SERVICES

Gamma globulin (to build temporary resistance to polio) distributed to every State health department.

Use of teams of professional skills in diagnosing and treating oral clefts increasing.

Health problems of migrant children made the focus of conferences and interagency committees.

Puerto Rico holds 3 institutes on child growth and development.

Regional congenital heart disease centers operating in Baltimore Chicago, Dallas, San Francisco.

States push ahead on improved programs for premature infants.

842 communities (with 16 million people) have fluoridation of water supplies in operation.

Groups of parents of mentally retarded and physically handicapped children grow in number and activity.

Nursing consultants in maternal and child care outnumber such nurses in other specialized programs in State health agencies.

States, concerned with the growing number of blind young children, explore possible services for them.

Only a few of the noteworthy developments in child-health services are flagged here, but these few show the great variety and spread of services throughout the country. Basic health services reach large numbers of children; specialized services of this kind reach relatively few.

15 years' experience in medical social work in State maternal and child-health and crippled children's programs has been reviewed, analyzed, and evaluated. The results appear in Children's Bureau Publication 343, MEDICAL SOCIAL SERVICES FOR CHILDREN. This publication is expected to be of value not only to medical social work practitioners and students, but to all personnel working in public-health and medical-care fields. Copies may be purchased for 20 cents each from the Superintendent of Documents, Government Printing Office, Washington 25, D. C.

some hurdles for health services

While major gains for the health of children continued during the year, there was also evident increasing caution in the development of more services, owing to the prevailing trend toward economy.

At the same time, requests for help showed no slackening. High living costs and high costs of hospitalization and medical care make it difficult for many families to finance adequate care for their children.

Shortage of trained personnel for positions in State agencies continues to be a major problem. Since the war fewer physicians have been entering public-health work. At the close of the year there were 14 vacancies in the

directorships of State maternal and child-health and crippled children's agencies.

Premature birth, a major problem, is very costly. Only an occasional hospital-insurance plan provides for the newborn period. Early hospitalization of mothers who have complications of pregnancy would reduce prematurity, but few State health departments provide such care for mothers.

Services for children with handicaps other than orthopedic are limited geographically. About half the children who receive physicians' services under State crippled children's programs are orthopedically handicapped, but this group is not the most numerous among handicapped children. The job ahead is to achieve as general geographic coverage for other crippled children as now exists for the orthopedically handicapped.

TROUBLE SPOTS

CHILDREN IN MIGRANT FAMILIES

For many years low economic status, poor and unsanitary housing, child labor, lack of educational and recreational opportunity, lack of care for children while mothers work have characterized the life of children in the families of migratory agricultural laborers. Many other children suffer from conditions somewhat similar, but the child of migrants has the added disadvantage that usually he belongs to no community.

As the migrants move from south to north following the ripening of the crops, they pass through one State after another, staying only a short while in any State.

There may be as many as a million children of migratory farm workers in our Nation. A great proportion of these children are not accepted by the communities through which they pass. Many of them are denied the health, education, and welfare services to which others are entitled, or they have intermittent help only. And they lack the feeling of security that comes through acceptance by neighbors and schoolmates.

Besides, too many of their parents are ignorant of what is available to them in a strange community.

It is a rare State, indeed, that does not feel the ebb and flow of these migratory workers.

For years the plight of these children has been investigated, talked about, and reported. Progress in alleviating their conditions has been slow. At one moment, because they move from State to State, they are considered a Federal responsibility. At another time, because States ask for and use migrants, States are expected to assume responsibility for them.

The areas where these families work on crops sometimes lack local

health units; they may be without child-welfare services; and they may lack sufficient school facilities to accommodate migrants. Besides, the children may receive little protection from child-labor laws, for these often do not apply to agricultural labor.

If conditions are to improve for the children of migratory families, local health units will have to be established, schooling planned for, and child-welfare workers employed in key places. Regulation of child labor will have to be strengthened. Day-time care for children whose mothers are at work in the fields is also needed. And something should be done to help



these children gain some continuity in their lives.

Spots where community action has succeeded ought to be studied, and the benefit of this experience shared with other communities and other States or groups of States. Methods by which States can work together cooperatively for these families have yet to be developed.

Through the Interdepartmental Committee on Children and Youth, the Children's Bureau is working with other Federal agencies in a joint effort to help States develop plans that will result in a better life for the children of the agricultural migratory workers.

The Children's Bureau has had its eyes, most particularly, on the East Coast migratory stream, involving the States from Florida to New York. In this stream are some 26,000 people who work primarily at harvesting fruits and vegetables.

The purpose of such a project would be to get services to children started in the home base and continued, in an integrated fashion, wherever the children go. This would involve working with health, education, and welfare agencies of the States along this route; working with the migrant parents so that they know what services can be used; and working with other Federal agencies and national organizations so that they tie into the network. Already there is much local and State interest in this team approach to a long unresolved problem.

JUVENILE DELINQUENCY

The year 1953 will be known as the year of mobilization for a major advance on one of the oldest problems of society—juvenile delinquency.

Need for action had clearly become acute. Delinquent behavior by youngsters, it was obvious from juvenile-court records, was increasing. From 1948 to 1952, the number of youngsters appearing before the courts had grown 29 percent. This was almost five times the percentage increase in numbers of teen-age boys and girls.

The prospect for the future, too, was disturbing. By 1960, it is expected there will be 40 percent more children between the ages of 10 and 17 years than there were in 1952. Even if the rate of delinquency stood at its 1952 level, the number of youngsters picked up by the police, for instance, could mount from 1,000,000 in 1952 to 1,400,000 in 1960 because of the growth in child population.

Not only have numbers of young delinquents been increasing; reports seem to indicate that serious violations of law appear to be more numerous. Fingerprint arrests, recorded by the FBI, show that in 1951 auto thefts by juveniles were up by more than half from their 1948 level. Robbery had increased 25 percent; burglary, 15 percent; assault, 10 percent.

During the first 6 months of 1952, according to the FBI, a greater number of serious crimes were committed by boys and girls 18 years old than by persons of any other age.

People who work most closely with delinquent children know how involved and complex this problem is. Indeed, the very causes of juvenile delinquency are far from completely understood. A great deal of research into causes, preventives, and treatment is called for.

Enough is known, however, about the personal problems of youngsters who get into trouble with the law and about their family and community backgrounds to provide sound guidelines for action.

Agencies in contact with delinquent children find many difficulties in their efforts to deal effectively with such children.

Across the country, these agencies—whether police, courts, social-service agencies, detention homes, training schools—report that it is hard for them to find the kind of staff that knows how to deal with disturbed and rebellious youngsters. Too often these agencies have to follow antiquated ways of working because there has been a lack of agreement as to what are good practices or a lack of support for putting such practices into operation. In many places, even the physical structures for housing delinquents are bad.

Behind these shortcomings is the most serious one of all: citizens in general have not been helped to see how essential their aid is to the prevention and treatment of juvenile delinquency.

The world is excited right now at the prospect, in the next 5 or 10 years, of victory over polio, one of the great enemies of childhood. Such a victory

could be won only with laymen and experts together working for it.

Juvenile delinquency is of course not caused by a virus that can be isolated in a laboratory; it cannot be prevented by anything like inoculation. Nevertheless, as with a physical illness, if we are to prevent and treat delinquency effectively we must have the same kind of team play.

As a move in that direction the Children's Bureau early in the fiscal year created a Juvenile Delinquency Branch in its Division of Social Services. During the year, various private foundations and individuals financed a Special Juvenile Delinquency Project to work with the Bureau.

Together, the Bureau and the Project, with the help of hundreds of specialists from a wide range of professions, have been firming up plans for focusing public concern on the situation and for spark-plugging community action in behalf of delinquent youth.

Meetings were held during the year with representatives of some 90 national organizations concerned with this problem. These included health, welfare, educational, and civic groups.

Expert help was enlisted in preparing guides to better practices in the treatment of delinquent children. These guides cover police handling of youngsters; juvenile courts; institutions for juvenile delinquents, and the training of staff for these agencies.

Handbooks for civic groups were published: one, to alert citizens to the size and seriousness of the problem; another, to tell them how services for delinquent youth might be improved; a third, to show how citizens can find out what needs doing in their own communities.

Already these handbooks are going into active duty through some of the outstanding civic organizations of the Nation.

A round-up of research, completed and in process, was made.

In these and other ways a wide variety of facts and forces were mobilized in 1953.

These will be strengthened, undoubtedly, as a result of the hearings being held in the fiscal year 1954 by

the Subcommittee on Juvenile Delinquency, created by a resolution of the United States Senate to inquire into the extent, character, and causes of juvenile delinquency, and into the adequacy of existing provisions of law



for dealing with delinquents and youthful offenders.

To put this newly gathered information to work is our task for the immediate future.

MENTALLY RETARDED CHILDREN

Large numbers of families have a child who is mentally retarded. The exact number of such children is not known; but among school-age children in this country the Office of Education estimates that 2 percent are retarded.

Most of these children are only moderately retarded, and if they are helped and encouraged and given special teaching many of them make a reasonably adequate social adjustment, and can also learn limited skills in school subjects. After patient and skillful training in a special class and at home and with good vocational counseling, many of these children can later hold simple jobs and be at least partly self-supporting. But as yet only about 25 percent of the moderately retarded are in special classes.

The severely retarded are much fewer (perhaps 1 child in 1,000 of the general population). Even among these the majority can be helped to achieve a limited amount of social adjustment. And after they grow up a number of them may be able to do some useful work in their own homes or under similar sheltered conditions. A few hundred school classes for the severely retarded have been established but these cover only about 4,500



children. Educators are hopeful of extending this program.

Whether it is the parents or the school authorities that first suspect that a child's mental development is not normal, the skills of a variety of experts are needed to make an adequate diagnosis and to develop plans that will best help the child and his family. Skills of the family physician or school physician, the psychologist, and the social worker must be combined, and often need to be supplemented by those of the psychiatrist, other medical specialists, the dentist, and the speech therapist. The team sometimes needs to keep the child under observation for a considerable period before making a diagnosis. Unfortunately, in many localities the complete services of such a team are not readily available.

Diagnosis alone is not enough, of course. The parents will need a great deal of help but if they know they have been given an expert diagnosis and are helped to understand their problem they are less likely to go from doctor to doctor, or from clinic to clinic, seeking hope.

To help families carry out the program recommended, professional skills are needed. In some places more and better facilities for such help need to be developed. In others, agencies already exist that can help and would be willing to do so; but the families may not know about them. Teamwork on the part of education authorities, social agencies, and medical services in the community is needed to acquaint parents with the resources available and to provide complete and integrated services.

Many parents need to be helped to accept the child as he is. Some expect too much of the child and resent his not keeping up with their expectations. Others tend to overprotect him.

Even if a child really needs institutional care—and some do—the institutions for the mentally retarded have long waiting lists, and cannot admit all children who need such care, especially the younger ones. When the severely retarded child remains at home, as a rule the mother needs to

be helped and encouraged in her efforts to care for him and to teach him even such simple things as dressing and feeding himself.

When a skilled social worker is available to visit the child's home regularly and guide the mother's efforts, it has been found the child may progress enough that the mother gives up her former idea of sending him to an institution.

Like other children, a mentally retarded child needs opportunity to develop through play with others of his own age. Group care of such children would not only provide valuable opportunities to the retarded child but would also relieve the mother—for a few hours—of the strain of constantly caring for the child. Some nurseries and kindergartens for the mentally retarded are being developed.

In the now widespread efforts to improve the opportunities for mentally retarded children much of the initiative has come from parents. This movement began some years ago in a few local groups of parents. Now 241 such local groups, representing more than 40 States, are united in the National Association for Retarded Children. This association, which works to promote the welfare of mentally retarded children wherever they are—at home, in institutions, or in schools of any kind—recently held its fourth annual convention. More than 700 persons attended this convention—not only parents, but also professional workers and others.

Comparatively little is certain about what causes mental retardation. Undoubtedly retardation in many children is due to conditions existing before birth, some of which may some day be preventable through greater medical knowledge. It may happen in some cases that social and psychological factors produce the appearance of mental retardation in children who have potentially normal intelligence.

If we understood better what may be some of the multiple causes of mental retardation, as well as its multiple forms, perhaps we could prevent it in many children. But before such prevention is possible a great deal more research will be necessary.

FOR CHILDREN IN OTHER LANDS

ONE FEBRUARY DAY in 1953, a little group of Americans arrived in Samawa, a town along the Euphrates River in Iraq. They were a maternal and child-health physician, two nurse-midwives, and a laboratory technician. They had come to open the first maternal and child-health center to be established in that country. A few months later they were joined by a pediatric nurse from the U.S.A.

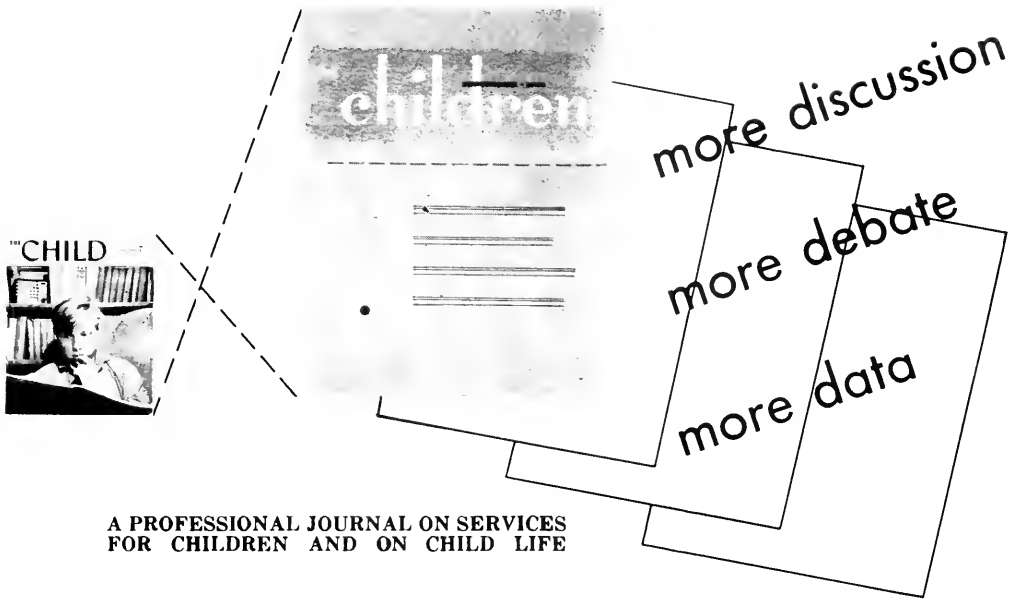
During the first month of operation, the maternal and child-health center cared for 122 maternity patients and some 400 sick babies. Five months later, 239 mothers and 629 babies were cared for. Of the babies, 153 were well babies, brought to the center for physical examination, for advice to the mother on care and feeding, and for immunizations.

In an area where preventive services for children were unknown, the attendance of so many well babies is no minor achievement. It spells the beginning of an understanding of preventive health measures by the mothers of the community.

Four of these five professional workers were recruited by the Children's Bureau for projects abroad sponsored by the Department of State's program for technical cooperation (now administered by Foreign Operations Administration). During 1953, six other workers in maternal and child health and five in child welfare served abroad and were given technical support by Bureau staff members in carrying out their overseas assignments.

The Bureau, during 1953, also carried responsibility for programs of observation and study in this country for 67 long-term trainees from 30 countries, and for 264 short-term visitors. The trainees' interests include maternal and child health and various aspects of child welfare, including the prevention and treatment of juvenile delinquency.

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Under authorization of the Bureau of the Budget, September 22, 1953, publication of THE CHILD is discontinued with this issue. In its place, CHILDREN will be published 6 times annually. The first issue of CHILDREN will be January-February 1954. Subscription price for CHILDREN will be \$1.25 a year. Single copies will be 25 cents each. On all orders of 100 or more sent to one ad-

dress there is a discount of 25 percent. Single copies of THE CHILD are still available at 15 cents each.

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Statements and opinions of contributors not connected with the Children's Bureau are their own and do not necessarily reflect the Bureau's position.

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